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MEDICAID ISSUES AND PERSPECTIVES

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

ON

GOVERNORS' AND INTEREST GROUPS' PERSPECTIVES, HISTORICAL OVERVIEW, AND STATE FLEXIBILITY OF THE MEDICAID PROGRAM

JUNE 28, 29, AND JULY 12, 13, 1995

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MEDICAID: GOVERNORS' PERSPECTIVES

WEDNESDAY, JUNE 28, 1995

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 11:05 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman of the committee) presiding.

Also present: Senators Grassley, Moynihan, Baucus, Pryor, Rockefeller, Breaux, Graham, and Moseley-Braun.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Gentlemen, the committee will come to order. I apologize. Of all of you, Lawton knows most what we have been going through with the stacked votes back to back to back, and I am embarrassed that we have kept you waiting this long.

I do not know how we could have a better cross-section or panel for the subject that we are starting today, which is Medicaid. We will have a number of hearings. You know the issues and the arguments as well as we do. We have hamstrung you in a dozen different ways as to how to administer Medicaid, without giving you much freedom.

You know our budget problems, I think we know your budget problems. Unless I miss my guess, in each of your States, Medicaid is either the first or the second biggest expense, depending upon how much education you finance at the State level. It could be bigger given that situation.

But it is an immense problem, and it is an immense expense for all of us. We are going to try to narrow the increase in the spending. No one is talking about it going down. We are going to try to narrow the increase.

Then, and I did not realize it until several weeks ago, the formula battle. Even if Medicaid, instead of going up 10 percent were to go up 7 percent, I sense we are still going to have a formula battle.

And, Pat, what I would love to do is to say to the National Governors' Association, why do you not unanimously agree on a formula that we can accept, within the constraints of the amount of money that we plan to spend, and see if they could unanimously reach an agreement on that subject.

Senator MOYNIHAN. Mr. Chairman, they are still smiling.

The CHAIRMAN. And that is the only statement I have.

Pat?

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. I want to welcome our friends and say that we do look forward to your testimony. And, if you would, find a moment to address this question of the formula.

As you know, the Medicaid formula is basically still the formula of the Hill-Burton Hospital Construction Act of 1946, I believe, and it is based on the square of the difference between median income of the State and the median income of the Nation.

When I first came to this committee, Mr. Chairman, you may remember, I introduced a small bill that said, instead of square, what do you say we have it be square root. I tried that out with Russell Long, and he explained to me that the Hill-Burton Act was the South's revenge for the Civil War, and he could not change that formula. So, here it is with us to this day.

Governor CHILES. Senator, he probably called it the War Between the States. [Laughter.]

Senator MOYNIHAN. Yes, sir. I think you are right. I think you have got that correct. On that cheerful note, we look forward to the testimony.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Mr. Chairman, I appreciate your holding this and the subsequent hearings on the Medicaid plan. In light of the fact that we are late starting, I will defer my opening statement, and look forward to hearing from the Governors who have joined us today.

The CHAIRMAN. Thank you.

Gentlemen, Lawton, we start with you, first. As I said, Lawton used to be Chairman of the Budget Committee in the Senate, and only he could appreciate what Pete Domenici is attempting to go through now.

Oh, Jay. Senator Rockefeller, did you have an opening statement?

Senator ROCKEFELLER. No, I do not, Mr. Chairman.

The CHAIRMAN. Lawton, go right ahead.

STATEMENT OF HON. LAWTON CHILES, GOVERNOR OF THE STATE OF FLORIDA

Governor CHILES. Thank you, Mr. Chairman. I am delighted to be here today to have a chance to testify, and I do know exactly what Pete's going through and what this experience is.

I think it is interesting that we find ourselves here today, we are kind of arguing about the formula, and thinking that, in less than a year, we have come full circle from whether we were going to have 95 percent of universal coverage, and the big argument of whether we went to 100 percent, or whether we were 90 percent, to now we are cutting a half trillion dollars, knowing that we are going to have to reduce coverage.

The watch-word, of course, we hear as a Governor is that, not to worry, we are going to give you flexibility. We want flexibility, certainly, but we hear flexibility and then we sort of look at numbers and we wonder how far we can go with flexibility. We know that we can achieve reforms and real savings in the State.

In Florida we have already embarked on that course. Almost all of our States are forced to do that by virtue of our share of the money that goes into these programs. We have reduced the rate of growth in Florida by 50 percent. We are implementing alternatives to long-term care. We have to do that in Florida with our heavy aged population. The fastest growth of the population area in our State is people over 85. We have imposed strict price controls on providers.

As recently today, I am reading things where the stock in some of our HMOs have just dropped 25 percent because of a lot of recent price controls that we have put out. We have placed more than 650,000 AFDC recipients in managed care, and next year we will have over a million.

So, by next year, over 60 percent of our AFDC recipients will be in managed care. Over the last three years, we have reduced our percent of recipient spending by 2–3 percent a year. While the national average was going 7–8 percent a year, we have reduced ours 2–3 percent. Our current spending per recipient is under $2,400. We are ranked 44th in the States.

Then we are told that we are going to be able to achieve 20 percent reduction without reducing coverage. We need to remember that the people we serve in Medicaid, over 70 percent of those people are the aged, the blind, the disabled. In our State, I have told you, the fastest growing population is over 85. So that explains my concern over the so called flexibility in the block grants.

We believe in efficiency, but CBO has now told all of us recently that we may be only able to achieve about $5 billion of $180 billion in savings through managed care and through the repeal of the Boren Agreement.

So what does flexibility mean? Shift billions of dollars in cost to the State, local and private sector? That is what we are seeing that it means, and, of course, by having to reduce coverage.

We are concerned about removing any responsibility of the Federal Government from being responsible for the aged, the disabled, the blind, and sort of putting Florida and the other States out on an ice flow and saying to them, now, you cope with recessions. The last recession, our Medicaid increased 25 percent.

Now, someone is going to have a cash emergency fund. Florida's 25 percent would eat up about any fund I think you all were talking about in a very short period of time. After Hurricane Andrew, we went up 15 percent in Dade County the first month. So, Florida stands ready to share in the cuts.

We feel we have gone a long ways to reduce our costs. I certainly think the overall level of cuts in the resolution is too high, but that is a question of the votes and the votes have said it is going to be that high. Now I have to come to you and say, if you are going to cut $182 billion, please do it fairly. Distribute those cuts fairly.

We certainly have a plan that would apply the cuts fairly to all States; maybe every State has a plan they support. But for years Congress has been told by the General Accounting Office that the funds in the Medicaid program are not targeted to the areas that are truly in need.

In this new formula, if we are talking about fairness, if we are talking about flexibility, the dollars need to go where the needy live. And as Congress looks at capping the program, it should account for differences in population growth, in poverty, in uninsured rates, and the percentage of elderly and disabled in each of the States. I am not alone in sharing that view. Many Governors, especially the Governors in the growth States, feel that way.

The United States was founded upon the simple but unwavering belief that all people are created equal. That principle is undermined and on the verge of being abandoned through a block grant proposal that values people differently.

I would like to end by putting it simply. The debate in Congress should not be about developing a Michigan block grant, a Massachusetts block grant, or a Florida block grant, we should be talking instead about a true Federal/State partnership for health care.

With a true Federal/State partnership, a child in a family in Florida is worth as much as a child in a family anywhere else in the United States. Any proposal leaving Washington should recognize that truth.

I would like a program that enables me to address the particular needs of growth in Florida, a program that allows me to continue the reforms that show great promise for care, as well as savings. A true Federal/State partnership for health care is one that has flexibility, but is one that recognizes the Federal Government's responsibility as a continuing and a contributing partner.

Richard Nixon championed this approach as much as Ronald Reagan. Both argued the Federal Government must share the fiscal burden and ensure equal treatment of all those in need. The States are willing to share the load. We want the Federal Government to cooperate, to be our partner. That is what a partnership should be about.

Thank you.

The CHAIRMAN. Lawton, thank you.

[The prepared statement of Governor Chiles appears in the appendix.]

The CHAIRMAN. Now, Governor and Doctor, Howard Dean, from Vermont.

Governor?

STATEMENT OF HON. HOWARD DEAN, GOVERNOR OF THE STATE OF VERMONT

Governor DEAN. Thank you, Mr. Chairman. I am going to be brief. I do have prepared testimony on behalf of the NGA, as NGA Chair. Then we got a call from your staff late last night saying they also wanted some prepared testimony speaking as Vermont's Governor, so we sent that.

Because you have had votes and we have gotten a late start, I am going to try to use up a lot less than my 10 minutes and try to just get right to the quick.

Speaking for myself as the Governor of the State, you have asked us to put on the table, perhaps, a solution to see if we could all agree on a funding formula. Perhaps we would not be able to do that, but I would suggest to you that the best way to eliminate disagreements over funding formulas, instead of using block grants, is use capped entitlements, as the President suggests.

We can argue about what number that should be, but a capped entitlement essentially gives the States budget flexibility because, if you suddenly have a recession, or you have 12 percent growth as they are out in the west or in Florida, then you have got some flexibility in the grant.

If you just give us a plain block grant, the high-growth States certainly are going to be hurt and we certainly will have a big fight about the formula. I think Governor Thompson and I would probably be united against some of the other Governors, perhaps, sitting at this table, just as many of you would be at each other's throats over a funding formula based on a block grant. So a capped entitlement will get you past the block grant argument over which State gets which, regardless of party.

The CBO came out last week with something that was very disturbing to me, and I would just confirm something that Lawton Chiles just said. They believe there is $5 billion worth of savings to be had out of the $182 billion in terms of managed care and flexibility. I think that may be right. We have just gotten agreement, in principle, on a waiver—which was hard negotiation, as usual, with HCFA and OMB—and our waiver calls for about a 6.3 percent trend line.

That is based on national trend line today and increase in Medicaid spending, so that our baseline has dropped dramatically, the national spending has dropped dramatically.

Ours will because of our waiver. We are going to be limited to a 6.3 percent increase, which is actually very close to the numbers that you all have been talking about here in Congress, starting with 10 percent, or eight percent, and then ratcheting it on down to four percent, where we end up somewhere in the middle.

We hope that the waivers are going to be respected, as the waivers that we all, both Republicans and Democrats, have gotten in whatever bill comes out.

We think that is very important because we have all taken creative opportunities to reduce our own Medicaid budget. But many of us believe that it is a good thing to have a Federal/State partnership, and we think that a capped entitlement will resolve some of your problems among your colleagues in dealing with which State gets what.

Finally, let me just conclude by making a few very specific remarks. There has been a lot of talk about putting things back to the States, and the States can do a better job, and so forth, and so on.

If that is true, and if Congress adopts that kind of flexibility that we hope they will under either a block grant scenario or a capped entitlement, it is extraordinary important that the Congress repeal the Boren Amendment and get rid of some of the mandates in the OBRA of 1987.

The biggest time bomb in Medicaid, believe it or not, is not acute care. That is what we are all focusing on. One of my bottom lines is, I do not want one single person to be deprived of coverage, no matter what Congress does, and I think we can do that.

Scaling back benefits, we understand, will have to happen. There is not enough money to save inefficiencies and good management at the State level. I am willing to do that, but I am not willing to take anybody off coverage.I am in the business of trying to get everybody covered, not fewer people.

We cannot do that on the acute care side unless we have some relief on the nursing home side. Most Medicaid money in most States goes to long-term care, it does not go to acute care. So we have to have some relief from Boren, we have to have some relief from OBRA.

If you do not do that, and if the $182 billion that you have agreed to and which will be voted on today or tomorrow in the Senate should happen to be the number, there is going to be no acute care program left for any of our States.

We have to have flexibility on the long-term care side or we are dead, and there is no way we can manage this. If it is a capped entitlement, block grant, Republican, Democrat, that money will all go to long-term care unless we can get rid of some of those mandates, the most difficult of which for us in the Boren Amendment.

Finally, let me just say a few kind words about Senator Chafee's plan. I have looked at this. I think that it is a real opportunity for us. There are some mandates in there that I do not like.

I think the notion, for example, of not being able to put qualified Medicare beneficiaries into managed care is a prescription that we would not agree with, but I think he has done a lot of very thoughtful work. He is going to be an enormous influence, I know, on this process.

It seemed to me personally—and this is certainly not an NGA position—that that might be an interesting place to start to see if there can be some consensus on this very difficult subject.

So, thank you very much for allowing us to come and talk to you.

The CHAIRMAN. Governor and Doctor, thank you.

[The prepared statement of Governor Dean appears in the appendix.]

The CHAIRMAN. Next, we will take Governor Jim Edgar, from Illinois.

STATEMENT OF HON. JIM EDGAR, GOVERNOR OF THE STATE OF ILLINOIS

Governor EDGAR. Thank you, Mr. Chairman. I appreciate the opportunity to come and testify before this committee today. I, like, I think, all other Governors in this Nation look forward to working with you in the weeks ahead on this very critical issue. I think we all realize we have to work together to overhaul Medicaid, because there is really no alternative.

The Medicaid program is outdated and it is out of control. Its mushrooming costs have caused huge problems in State budgets across this Nation, and it is obvious that corralling this runaway expenditures is a major component of balancing the Federal budget.

The leadership of this Congress wants to significantly slow the growth of Medicaid. I and other Governors are prepared to do our part. In fact, we are eager to bring this budget-buster under control.

Medicaid accounted for 10 percent of total State spending in 1987; today it consumes twice that. But, if we are to help balance the Federal budget as well as balance our own budgets, we must have the flexibility and the freedom that I believe block grants would provide, flexibility to determine how we can best provide health care to the truly needy in our States, freedom from Federal micromanagement, and freedom, as has already been mentioned, from the Boren Amendment and other Federal restraints that undercut us when we sit down to negotiate with providers.

Federal micromanagement has made it virtually impossible to control Medicaid costs. In Illinois, the tab for recent Federal mandates topped $480 million this year. Because of those mandates and rising health care costs, we increased spending for Medicaid between 1991 and 1993 more than we were able to boost funding for education, child welfare, prisons, mental health, and law enforcement combined.

Let me repeat. We have spent more on Medicaid than all those other vital programs combined in the last 4 years. We are now spending in Illinois more than $6 billion annually on Medicaid, 64 times what we spent in 1966, the first year of the program.

This is not a partisan issue, as you can tell by the discussion here today. Republicans and Democratic Governors alike have been grappling with really a failed system. If we want to depart from the one-size-fits-all approach to Medicaid, now we must go hat-in-hand to the Federal bureaucrats. They delay and delay on our waiver requests and they are very reluctant—very reluctant—to surrender control.

You have given us the responsibility to manage Medicaid. Now, please give us the flexibility and the freedom to do it well. I am confident that all of us agree on the goals: cost-effective health care for the truly needy, especially pregnant women and children.

I would be amazed if any Governor has not made children one of their top priorities. I know in Illinois, in the last 4 years we have increased funding for almost every program dealing with children and we have had to make a lot of cuts. We made a special effort not to cut programs that deal with children. And I am sure Governor after Governor would provide the same testimony of what they have done in the last few years.

As I said, I do not think there is much quarrel over the goals. But the crux of revamping Medicaid is changing how we try to reach those goals. The Federal Government has dictated benefits that are far more generous than normally provided to working men and women through private insurance programs.

Under the current Medicaid system, States cannot limit access to health care providers as a means to negotiate the best rates possible. Give us the flexibility to determine what benefits are fair and reasonable in our individual States. Give us the freedom that virtually every private insurer has to limit the choice of providers under preferred provider arrangements or managed care plans.

The States should be able to operate like any large insurer and negotiate the best rates with only the number of providers necessary to deliver the service, and we should be able to negotiate those rates free of the threat of lawsuits posed by the Boren Amendment.

Block grants, I believe, will give us the flexibility and the freedom we seek so we can help those all of us want to help in a more cost-effective manner. Working together, we can overhaul Medicaid.

I am sensitive to the concerns of Governors who worry about whether block grants will reflect changing populations and other factors. It will not be easy to deal with issues such as the fairest way to distribute funds, but I believe we can develop an approach that is fair to all States, as well as to the recipients and taxpayers, alike.

Clearly, the taxpayers of this Nation cannot afford to pay the skyrocketing costs of a broken system, and, thus, it will ultimately will fail the needy who rely on it for benefits. Massive reforms have been long overdue. It needs to happen now, and we, as Governors, look forward to working with you in the weeks ahead to make it happen.

Thank you, Mr. Chairman.

The CHAIRMAN. Governor, thank you.

[The prepared statement of Governor Edgar appears in the appendix.]

The CHAIRMAN. We will conclude with Michael Leavitt, of Utah.

STATEMENT OF HON. MICHAEL O. LEAVITT, GOVERNOR OF THE STATE OF UTAH

Governor LEAVITT. Thank you, Senator.

One out of eight people in our State is served by Medicaid. Obviously, this is a big stakes question for us. We have operated the last 30 years, as other States have, really on two principles.

The first, is to the extent we have been able to do so under Federal regulation, to operate on a competitive basis, to let the marketplace dictate the efficiencies, and, second, individual responsibility.

Back in 1981, we abandoned the fee-for-service and went to competitive purchasing. We have been using HMO products since 1982, so we have long ago abandoned the cost-based reimbursement system that has been abandoned by virtually everyone else, except to the extent that we are required to by Federal law.

In 1993, we adopted a bipartisan plan we call HealthPrint. It is a blueprint for market-based reform in Utah. Our objective is to have all of our citizens have access to some form of basic health care by the year 2000, and we are making substantial progress. But a major part of that has been to expand Medicaid to those who have not been able to have it in the general marketplace.

It has required a series of waivers that have been extraordinarily difficult to come by. It did not take me long as Governor to figure out that I did not have the flexibility that we would need to do so without going through this very difficult process, weaving our way through mandates, court decisions, and regulations. Our hands have been tied.

Medicaid, as you know, is not just one program, it is a very complex lattice-work of over 26 programs. Each one of them has their own set of rules, they have their own set of regulations, they overlap, they are sometimes contradictory.

The complexity is just unbelievable and the public is just not being served well by it. We are not keeping pace with the very fundamental and basic advances that are taking place, not just in the health industry, but also in private industry, as they deal with their cost containment challenges.

The fact is, the rules and regulations just do not bear any relationship to reality. I would like to just give you a couple of examples, quickly. They have been mentioned. The Boren Amendment. Clearly, our hands are tied. We are tied to a set of obsolete, bureaucratic, cost-based methods of being able to determine efficiency. The marketplace will be far better.

Another example is the so called optional services that we are able to opt in or opt out of. The truth is, when you get down to actually trying to opt out, there are so many subgroup rules it makes it virtually impossible to really opt out of anything. So, the ability to actually set priorities is gone.

Let me just give you one example. We have to make hard choices in balancing the budget, and also in this debate. We have made some hard decisions in our State. We went out to our low-income community and negotiated long and hard, and basically came up with this deal.

Medicaid is about 130 percent above, in richness of benefits, for what the average person in my State has, if he works in the private sector. So Joe Lunchbucket out in Magna, Utah, in my State, who works for a private company, basically gets a benefit package that is substantially below—nearly 30 percent below—what you would get if you were on Medicaid. Medicaid is the second-best benefit package in our State, with Medicare being the only one better.

Well, we made the decision that we would be willing to reduce benefits from 130 percent of the private sector down to 118 percent, still 18 percent higher than anyone working in the private sector would receive, and that we would use the money that we saved to give more coverage to people who currently do not have it who are in low-income categories.

That simply was not consistent with the national government's philosophy. Though there may be people here who disagree with that decision, that is what we wanted to do, that is what we negotiated with our low-income community to do, and we simply could not achieve it.

Now, those are the kinds of hard choices that have to be made. Our decision was, we would rather have everyone have some basic coverage as opposed to a few have the ideal. But we were not allowed to proceed with that priority, and I would suggest those are the kinds of basic decisions on reforms that are going to have to be made.

Another quick example, co-payments. Our hands are tied in a fundamental way to be able to achieve some level of sensitivity. We need to be able to use co-payments and other means of being able to bring people into reality with respect to cost.

Another area—this is an interesting one—administrative areas. The capacity for us to out-source is highly reduced. We are all struggling with how we would go about administratively achieving better efficiency. We have developed a system in Utah, we call it the Utah Health Information Network. It is a non-profit, voluntary system that will collect claims on behalf of all public and private insuring entities in our State.

As I mentioned, it is non-profit. It is totally voluntary. But they can process, receiving manually or electronically, claims under all entities. They are able to go through and sort and coordinate benefits. By bylaws, all of the organizations who participate have to take the savings and return it to those who are actually the users.

This is the kind of fundamental reform and just one example of the kind of thing we can do, if we are given the latitude to do it. They will not all work, but some of them will. When they do, we will share them and we will learn from other people's mistakes as well.

Now, I have just completed a term as the Chairman of the Western Governors, and, therefore, I must point out with respect to this formula decision, nine out of 10 of the fastest-growing States in America are in the west, so I have to add my voice to the concern over this formula.

Utah, in the next 10 years, will grow 19 percent. That is not dissimilar to many of the other western States. We acknowledge the fact that we are going to be reducing Medicaid expenditures or the growth in Medicaid expenditures by some $180 billion.

Given the flexibility, we can get that job done, but we absolutely cannot tolerate a system that does not acknowledge the difference between a State that is going to grow 19 percent in the next 10 years and a State that will have negative population growth, nor is it reasonable for us to have a system that would penalize a State that has aggressively managed to reduce costs and growth, and then allow a windfall to a State that may not have employed those techniques.

Western Governors have enacted a resolution that I will provide for the record that essentially calls for what we are all anxious for, and that is a formula that is fair and acknowledges the contemplated population shifts, that does not reward inefficiency, and, lastly, that provides some form of risk-shifting mechanisms.

May I say that I believe there are ways we can achieve that. Even if we were to look at it by establishing a multiple State insurance pool, which I will not take time today to deal with, but I think there are ways that we can do that that may even be outside of a Federal mechanism.

Thank you, Mr. Chairman.

The CHAIRMAN. Governor, thank you.

[The prepared statement of Governor Leavitt appears in the appendix.]

The CHAIRMAN. Our order of arrival this morning, Senator Moynihan was first, Senator Pryor, Senator Baucus, Senator Grassley, myself, Senators Graham, Rockefeller, and Breaux.

Senator Moynihan?

Senator MOYNIHAN. Mr. Chairman, you are Chairman of this committee. Go ahead.

The CHAIRMAN. Well, I appreciate that. I normally am here first. What happened is, I did not get the word to everybody quite early enough that we were not going to meet. Thank you. I will take that.

Senator MOSELEY-BRAUN. Mr. Chairman, I arrived. I was in the Banking Committee markup. So, if you would, add me to the list.

The CHAIRMAN. The only reason you were not added is because the list did not come out yet. But do not worry, I will not overlook you.

Governor Dean, so we understand the terms, what do you mean by a "capped entitlement?"

Governor DEAN. A formula by which the revenue to the State depends on how many people are entitled to Medicaid under some Federal guidelines, as you have now, with growth being capped. In other words——

The CHAIRMAN. Like our social service block grant that is a capped entitlement.

Governor DEAN. Well, there is a fine line between capped entitlements and block grants, and I agree with everything that Mike Leavitt said, except that I think you can accomplish a fair amount of that with a capped entitlement and get rid of your funding formula difference.

If you were to give us the kind of flexibility that Governor Leavitt was talking about—which I thoroughly concur with, we need to have co-payments, for example, and it would be much easier if we did not have to get a waiver to do that and other things like that—if the formula were funded such that you take the number of people we have on Medicaid today in Vermont, Utah, Illinois, or Florida, and then there is an entitlement, as there is today, if Governor Chiles' population, or Governor Leavitt's population grows and the Medicaid population grows a certain way, those people are entitled to service.

A cap comes in where you tell us that the amount of money that you are going to give us is four percent, eight percent, what you need to hit a budget target, but it is based, not on a block grant where we just get an amount of money no matter who is in the program and who is not, and after that just grows a little bit, no matter whether Mike's population grows 19 percent or mine grows two percent, which is obviously a big problem for Governor Leavitt, instead of that, Governor Leavitt's grant will rise with the number of people in his program, so it will eliminate the problem of——

The CHAIRMAN. Where does the cap come from then?

Governor DEAN. Right now, your costs are rising, not just by the number of people in the program, but also by an inflation factor that is about 2–3 times higher in medicine than it is in CPI. The cap comes from just simply lowering that. You say to us, all right, Governor Dean, if you cannot control costs in Vermont, that is your problem. We are going to give you X per capita. Based on what you are getting now, that is going to be allowed to rise X percent. If your costs go up 10 percent, that is just too bad for you.

The CHAIRMAN. But here is my confusion. If we say ultimate flexibility, i.e., block grant, and we say to Florida, you get $1 billion a year for 7 years. That is a cap. Now, if, instead, we go to a capped entitlement, are you saying there is a way we can do that and still spend no more money than we spend under the block grants?

Governor DEAN. Probably not. But then we have a difference of opinion which is partly partisan, I suspect. We think you can make reductions. The President's reductions are $50-some-odd billion. Probably it is not reasonable to expect $182 billion worth of reductions under a capped entitlement, so there obviously has to be some way of reducing that.

I do not know what the number you can get is. It is obviously between $50 billion and $182 billion. I doubt very much whether you can give us block grants and make your budget target of $182 if that, in fact, is what passes tomorrow, but I can promise you that a large number of people will be off health insurance and will have no health insurance if that $182 billion figure should pass.

So what I am suggesting is that you take less out of Medicaid and that you cap what we get, which I think is reasonable. That will protect our budgets and it will solve the difference between Governor Leavitt and Governor Chiles, on one hand, and perhaps Governor Edgar and myself on the other.

The CHAIRMAN. My hunch is, if we took less out of Medicaid we might be able to solve the whole formula problem, too. The problem is the formula when it is not going up as much as it is going up now.

Governor DEAN. I think, Senator, no matter how much you take out, you are going to have a big formula problem. If the amount that you took out is less, and I would, of course, suggest fiddling around with the tax cuts a little bit—I thought that Senator Domenici's mark was far better than the compromise proposal—if that were to be a source of funds for Medicaid, then you could solve the differential and the argument in terms of growth, high-growth, low-growth States, but the per capita cap is the way, it seems to me, to make that work. I concede to you, there is no way to do $182 billion with a capped entitlement, but a capped entitlement is going to essentially make it possible, I think, to reform Medicaid in a reasonable way without costing people their coverage.

The CHAIRMAN. Lawton, let me ask you a question, now. On page eight of your statement you have three points. The third point is, does the program set and maintain an appropriate basic national standard for the care of children and others in need, or does it establish a new underclass in America?

I am assuming by that you are saying, even if we could conceivably come up with a formula that satisfied everybody, and they did not think they were going to be shorted, and that Florida is going to do as well as South Dakota, you would still be opposed to ultimate flexibility, i.e., a block grant with no national standards of any kind.

Governor CHILES. Absolutely. Having, I think, sat on the other side of where I sit now, in the one phase, as long as I am Governor I am going to take care of children in my State because that happens to be a strong persuasion that I have.

But, to me, part of this is my budgeteer hat, I think, that I continue to wear. If the Federal dollars are going for programs, there ought to be some responsibility of the States to account for or to provide for the dollars in which they are going.

You just give me a block grant, hell, I can spend the money anywhere. There are a lot of places that my legislature would like to spend that money that would not be taking care of children.

I have just gone through a budget situation in which I saw everybody wants to build prisons in my State. That is the popular thing. So they took money from my Health and Human Services and they took money that would go for people programs and they put it into prisons.

Now, to me, as stewards of the Federal dollars, if you are giving us money that is supposed to be for the aged, the disabled, there should be some standard that you hold us to.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Well, I think we all would agree with what Governor Chiles has just said. But I do not know if that is where we are going to end up. You gentlemen have put a lot into play, as I am sure you know.

We started out with the Aid to Families with Dependent Children, which is Title 4A of the Social Security Act, and which, since 1935, has been an entitlement; States get a Federal match for whatever they spend. The proposal was made that it be a block grant, and, indeed, this committee has reported a bill that would do that, on the basis of the existing expenditures.

But guess what? There are those States that still think that they can do better than that and immediately began to propose that it be changed to a population base, or some such.

Governor Thompson of Wisconsin wrote to me to say that it had come to his attention that a few Senators had proposed changing the funding formula. I had to write back to him and say, by a few I assume you mean 30. Under the new plan, Wisconsin will lose 16 percent of its present level of Federal benefits.

Well, the Governor does not think that is a good idea. But we have a rule around here, it is called one State, two votes. Beware those who have been generous in the past. How to handle this is not going to be a pretty sight. It could mean all manner of dislocation, particularly in States such as New York, which would be devastated if we go the route some people are proposing.

Could I ask you, we are talking about growth of population, things like that. Do you think we ought to make some provision for cost of living, could I just ask anybody who would like to answer? Because cost of living does vary. It has never been part of Federal concerns. We have not built it into our formulas, but should we do so?

Governor DEAN. Speaking of welfare, Senator, or Medicaid?

Senator MOYNIHAN. Talking about hospitals and Medicaid.

Governor DEAN. My own view as a physician is that health care costs have been going up at twice the rate of inflation and the Senate has every right, and should as we should, demand that go down to something much closer to CPI.

Senator MOYNIHAN. But I am talking about variations between different parts of the country. There are very considerable——

Governor DEAN. In my view, that is an area that can be left to the States, because it is now.

Senator MOYNIHAN. Well, no. According to the formula, the Federal Government matches what the State spends.

Governor DEAN. But the States decide how much we are going to spend.

Senator MOYNIHAN. And that reflects their cost of living. Once you get into a block grant it will cease to be——

Governor DEAN. I see what you are saying. Well, in that case, I think I will leave that to my Republican colleagues to answer. [Laughter.]

Governor LEAVITT. Senator, there is no question that there will be no formula that will be devoid of a number of considerations. That has got to be one of them, but so does growth.

Now, the other point I would make is that there is at least a subtle factor in the formula now because States get to choose basically how much they will put forward, and they do that on the basis of their tax base, et cetera. There is no question about the fact that, whatever the formula is, it will have to be a composite of a lot of different things, but it cannot be devoid of growth as one of them.

Now, I will be quick to say as well, we like to think of these in very neatly compartmentalized kinds of programmistic issues, but they are not. It is clear to me that the Medicaid issue and the AFDC and welfare issue are all connected. A lot of them are the same people.

I cannot make this work in my State, even under the favorable conditions that we have, if I have to just take the Federal label off of all of these programs and now put a State label on them and do them the same way.

We literally have to take a clean sheet of paper and be able to work through them and completely rethink by asking fundamental questions that start with, what do people need in order to get their lives back together.

Senator MOYNIHAN. Or to go on with their lives when they are quite old.

Can I just say, sir, and thank you for your responses, but the existing arrangements automatically adjust for increased population and automatically adjust for higher levels or lower levels of cost of living. You are walking into an area where it would be very difficult to do both of those things. I sometimes wish you had thought it over a little longer last January, but here we are. We wish everyone well and we will do our best.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman.

I was just calculating. At the table this morning we have three former Governors present here on the Finance Committee, and we have additional members on the other side of the aisle who could not be present. So I think that all of us, or most of us, certainly empathize with where you are and with where your arguments lie.

It sounds so beautifully simple to say, let us give this money to the States and let the States decide. That has such a wonderful ring to it, such harmony. But I think my greatest fear right now with that concept, though that it is sort of playing jump ball out there in the States with the various forces and powers that be, and the interests that come before the State legislatures. Senator Chiles has stated that the priorities among his legislators seem to be to build more prisons. I think we see a great deal of interest in that in our State of Arkansas.

I think we have a very complicated issue here before us. I for one, want to appreciate your understanding where we are, because I think a lot of us certainly understand where you are.

I would like to give you just a composite of three or four ways that we use our Medicaid funding in the State of Arkansas and see if this is generally about where you fall out, and see if you subscribe to this.

We have about 40 percent of babies born in our State who are paid for by Medicaid.

Governor LEAVITT. Did you say 3 percent?

Senator PRYOR. 40 percent.

Governor LEAVITT. That is far different.

Senator PRYOR. What would that be in Utah?

Governor LEAVITT. It is about one out of three, so we are about 33 percent.

Senator PRYOR. Yes. Governor Edgar?

Governor EDGAR. We are about one out of three, a little bit above that.

Governor DEAN. We are also in that range.

Governor CHILES. We are closer to yours.

Senator PRYOR. About 40 percent.

We have, for example, in Arkansas, 85 percent of the nursing home patients today on Medicaid. Would that be a figure that would of correspond with the four States represented here? I am just trying to see the variations of how we spend our Medicaid dollars.

Governor DEAN. We are a little bit lower than that, but that is certainly the ball park.

Senator PRYOR. And I imagine Florida would be somewhat in that category.

Governor CHILES. 75 to 85 percent.

Senator PRYOR. Illinois and Utah?

Governor LEAVITT. We are about 60 percent. We have a much younger population.

Governor EDGAR. 65 percent in Illinois.

Senator PRYOR. All right.

And the prescription drug coverage for a large number of poor seniors, if we capped or if we had block grants, could be in grave jeopardy. Do each of the States represented here today utilize to the maximum extent the prescription drug coverage in Medicaid?

Governor LEAVITT. I do not know the answer as to the maximum amount allowable. I do not know the answer to that.

Senator PRYOR. All right. Well, we can get those figures later.

Senator Chiles stated in his opening statement on page three that they had been able in the State of Florida to actually decrease spending per recipient to the amount of three percent per recipient, where the national average has gone up 8 percent. I am just curious, to our good colleague and former Chairman of the Budget Committee in the Senate, how were you able to accomplish this?

Governor CHILES. Well, by putting more people into managed care we have embarked on that course. The second thing, was actually just by restraining the cost reimbursement that we would pay to the providers. So the combination of that, and literally policing better who was eligible and trying to scale down on over-utilization, is where you make the biggest savings.

Senator PRYOR. Mr. Chairman, I know that there are a lot of our colleagues who want to ask questions—I know Senator Graham has his Governor here—so I want to yield back the balance of my time.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

I think we have a very special opportunity here today with these four Governors who have front-line responsibility to move beyond theory and talk about some of the specific impacts of the proposals that are before us. So, in light of that opportunity, I would like to ask some rather specific questions, if I could start with Governor Dean.

Governor Dean, the information that I have is that if there had been a 5 percent cap, which is 1 percent above what is actually in the Conference Committee, where there is a four percent proposed cap, starting in 1987 and running through 1993, over that 5-year period Vermont would have received 25 percent less Medicaid funding than it actually received, but it would have been in a wedge arrangement.

That is, the losses in the last year would have been substantially greater than the losses in 1987, to the point that in the year 1993, Vermont would have had $170 million less than it actually received, which would have been 46 percent less than it actually received.

Had this program been in effect from 1987 to 1993 and you had had 46 percent less money in 1993, what, at a program level, would Vermont have done in order to accommodate that kind of a reduction in Federal Medicaid support?

Governor DEAN. A lot of it depends, Senator, on the amount of flexibility that we would have had with that kind of reduction. In our State we have virtually insured every child under the age of 18 at an income level of $33,400 or less. Obviously, that never would have happened. We insure pregnant women and infants up to 185 percent of poverty. That never would have happened. Had we had no flexibility we would not have had dental benefits, et cetera, et cetera.

Had we had flexibility, we would have taken some of it out of the providers' hide, which will happen under this new budget arrangement; we would have instituted co-payments, which I believe we should do; we would have put people into managed care sooner, which we are doing, although we are doing that anyway, and we think we can live with about a 6.3 percent increase there. It would have been very, very difficult.

Certainly there would be no prescription benefits for the elderly or any of that kind of stuff under the current rules, and it would be difficult to sustain that, even if we had had maximum flexibility.

Senator GRAHAM. What proportion of your Medicaid budget is spent on the elderly?

Governor DEAN. It is around 50 percent. I think it is a little bit higher, but I do not have an exact number. It is approximately 50 percent.

Senator GRAHAM. In terms of the types of initiatives you outlined, what would you have been able to have done relative to reducing the reimbursement to providers for those services that are particularly rendered to the elderly population?

Governor DEAN. Well, again, it depends on the flexibility. We did have a waiver which has stood us in good stead, and I assume that whatever comes out of Congress, whether an entitlement survives—which I certainly hope it does in some form—or whether it is a block grant, there will clearly be more flexibility.

An example of the kind of flexibility all States ought to have without a waiver, for example, is the waiver that we have for long-term care. We are allowed to use Medicaid dollars to take care of seniors in their own homes who would otherwise be in nursing homes, and that has saved us, and we have tried to reduce the number of nursing home beds, or at least stopped the growth.

One of the things that would have happened, frankly, Senator, is that the standard of care in our nursing homes would have gone down had we had that happen. We simply would not have been able to reimburse our nursing homes consistent with what the Boren Amendment has demanded, and the amount of reimbursement to the nursing home industry would clearly have dropped, and it will drop under the budget proposals. We have to get the money from someplace. We certainly can't raise taxes on our own people any more than the people here want to raise taxes.

Senator GRAHAM. Governor Edgar, some of the same statistics for Illinois. Had this plan been in effect from 1987 to 1993 at a 5 percent level, Illinois would have received $2.8 billion less than it in fact received over the 5-year period. In the last year, 1993, it would have received $1.3 billion less, or a 51 percent reduction. Assuming you had maximum flexibility, how would Illinois have assimilated a 51 percent reduction?

Governor EDGAR. Well, with maximum flexibility, I take it we would not have the Boren Amendment, so I think we would be in a better position to negotiate better rates with providers. I would take it to mean we also would not have the OBRA mandates that, as I mentioned, this last year cost us $480 million in Illinois alone.

Senator GRAHAM. What are some of the mandates that you would not follow if you had the election as to whether to comply or not to comply?

Governor EDGAR. Again, the most frustrating mandate is the Boren Amendment and what comes about as a result of that. I mean, it puts us at a big disadvantage, as I said in my testimony, versus what most insurers can do, and they can negotiate the price from the providers.

We also have found it frustrating. Governor Dean just mentioned trying to deal with the long-term care, being able to provide an alternative for nursing homes. Again, we have waivers from the Federal Government, but that is a very time-consuming process.

We would like to have gone to managed care. We have had a waiver request in now for almost a year. Many other States have done it. It seems like that too often we have all got to go through the hoops that some other State has done and has proven that it makes sense to try.

So, again, those types of mandates not telling us how we can fund our system, how we can deal with our system, and saying you can come in for waivers has proved to be not that effective a way of trying to change our programs to make it more cost-effective.

Senator GRAHAM. In the waiver request that you currently have pending—and I know my time is up—did you request all of the discretions that you have just indicated would have made your program more effective?

Governor EDGAR. Well, we are talking about managed care, basically. We did not get into the Boren Amendment and all that. They could not give us a waiver on that. But we did ask for a managed care approach which was approved bipartisan by our legislature by almost unanimous vote, which is pretty unheard of in this area. But the process is drawn out. I mean, the bureaucracy moves very slowly, to say the least. As a result, this new budget we just enacted, we could not put that into the budget because it had not been approved. There are several millions of dollars in savings that we have lost because we have not received a waiver.

Again, I think the flexibility issue, I do not know who said that all this sounds kind of too simple, but it is extremely frustrating from our point of view when we see other States have tried approaches that we think makes sense, and we have got to go in and do the waiver process, and it just drags out for months and months and into years in some cases. To allow us to be able to do that much more quickly, we think we can do a better job in recognizing we are probably not going to have as much of an increase in Medicaid as has been projected in the past.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman

A question for Governor Edgar. I am going to posit a few sentences here, so let me do that.

Governor EDGAR. Take as long as you like if it is positive.

Senator ROCKEFELLER. The Republican budget resolution which you and your Republican colleagues are supporting, generally, this morning would reduce Federal spending on Medicaid, Senator Graham indicated, by $182 billion over the next 7 years.

Now, the Kaiser Commission on the Future of Medicaid recently issued an analysis of impacts on States, and they did so on Illinois. It was done by economists and by the Urban Institute.

What they found was that over the next 7 years, Illinois would lose $6.2 billion in Federal Medicaid funds, a cut of 18.7 percent. In the year 2002 alone, Illinois will lose $1.8 billion in funds, a 1-year reduction of 30 percent.

Now, the researchers looked at the impact of these cuts on beneficiaries. They assumed that the States would control spending by enrolling beneficiaries in managed care and by reducing covered services, and also by cutting provider reimbursement rates.

Only after States made all of these changes, if that is what is to happen, did the researchers assume that they would cut back on enrollment, so that was sort of the very last factor.

What the researchers concluded was that, despite aggressive use of managed care and reductions in provider payments and in covered services, States would still have to cut back on coverage. They estimated in the year 2002 alone, Illinois would have to eliminate coverage for more than 82,000 people, that being 59,000 mothers and children, 7,000 elderly, and 17,000 disabled persons.

In short, they do not think that you can deal with these cuts in Federal funding. They do not think you can deal with it without stripping people in your State of their health care coverage.

Now, their analysis is, in fact, conservative. It does not even take into account the special problem that your State now faces, that is, the roughly $1 billion that you already owe hospitals and other providers for services rendered in the past.

You recently had a $1.3 billion debt, but the State legislature, I guess, adopted a cut of $200 million in that, so it is reduced somewhat. There was a cut of $200 million from welfare programs for disabled people that the legislature did, for abused and neglected children, and dental care for the poor in order to help pay down this debt that you do owe.

About $40 million of these savings comes from reducing payments to blind and disabled adults, the payments, therefore, going from $154 to $60 per month. That has been done.

According to a recent article in Crane Chicago Business, the same budget also reduced payments to hospitals with heavy Medicaid patient loads by 85 percent, from $400 million to $60 million per year. The biggest losers were Mt. Sinai Children's Hospital, Children's Memorial, Northwestern Memorial, Rush Presbyterian, University of Chicago.

In short, it appears on the face of it just blindingly clear to this Senator that, in a sense, your State is already robbing Peter to pay back Paul, and all of this occurs before the Republican budget cuts start with $190 billion, or whatever it is.

So the question I have, obviously, which I know you are dying for——[Laughter.]

Senator ROCKEFELLER [continuing]. Is what is your plan; how are you going to deal with the $6.2 billion loss; why is this flexibility so wonderful; which services are you going to stop covering, which benefits are you going to end coverage for under the block grant that you are seeking?

We will presumably repeal the Federal rules that say States have to pay providers on a timely basis for the services they deliver. Are you going to pay back the Illinois hospitals the $1 billion you owe them, or do you intend to use your flexibility to withhold payments from providers in the future as well?

The CHAIRMAN. Sorry, Jim. His time is up. [Laughter.]

Governor EDGAR. Two weeks ago when Congressman Waxman asked me the same question, I asked if I had as long to reply as the question. Let me, first of all, say I agree the current Medicaid situation in Illinois is not good. That is why we are here, because the current system does not work. The current system has put us in that situation.

So I think that what you just quoted, the status in Illinois, is the best reason I can think why we ought to have a massive overhaul of Medicaid.

Second, let me say on the——

Senator ROCKEFELLER. The question was, what are you going to do? This is all going to pass.

Governor EDGAR. I still have more here.

Second, let me just correct some facts. A little less than $1 billion is for all, not just hospitals. As you said, we were going to pay the hospitals. Also, to be very truthful, there is always going to be $400 million in the pipeline. By the time they figure it out when they provide the service and they send it to us and we process that bill in 60 days, it is always going to be about $400 million.

So there is an amount there that we are trying to reduce. And, if we had been able to receive the waiver that we had put a request in last year for with managed care, we think we would have gone a long way toward reducing that backlog even more. Now, that has been a situated I inherited and we have been trying to whittle it down, but we cannot unless we get some basic changes.

Also, not continue to add on mandates like the OBRA mandate that we have added on, to give us the Boren Amendment, where we have the flexibility.

So again, I will go back, we do not necessarily agree with the conclusion of the Kaiser study. You said it is conservative. I would question how conservative those figures are and what all they have taken into consideration.

We feel, if we are given the flexibility we now do not have and that we are able to manage—now, let me go back to the bigger point, this whole discussion, I think, has come about because there is a need on the part of the Federal Government to cut back their increases and expenditures in the years ahead to try to balance the budget.

I will be very truthful. You are a former Governor, you know that I would love to get all the money I can get. I think realistically we know we have to do our part, as everyone is going to have to do, if you are going to be able to balance the budget, and Medicaid is one of the big items. So, we are going to have to see less of an increase. Even President Clinton is now saying that, so we recognize that.

What we are saying is, give us the flexibility we think we can manage, even though it is not going to be pretty, it is not going to be easy. But if we are given the ability to negotiate with our providers and get a better rate than we now have, if we are able to go into managed care, if we are not saddled with more and more mandates in the years ahead, we feel like we can deal with this problem and still provide adequate care to those who truly have need and do it in a much more effective manner than we have been able to in the past.

Senator ROCKEFELLER. But does not your waiver ask for a 10 percent increase on top of population growth, whereas, of course, it is only a four percent increase that the Congress is talking about? Your waiver request is for a 10 percent increase.

Governor EDGAR. We are still negotiating on what we are going to get from that. I mean, I think if you have ever dealt with HCFA you know that when you go in, what you ask for, they never give it to you, so you sit and negotiate for months and months.

So, again, we feel, with what is being talked about as far as flexibility—and I have to say, four percent, I would rather have five or 6 percent, but four percent in the end, if you ratchet down, it is not all at once, and give us the flexibility, we feel that we can have a more effective program and still provide adequate care to the people of Illinois, and also begin to deal with the backlogs that have existed for several years in Illinois.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman. Thank the Governors. We have enjoyed working with all of you over the many months as we wrestle with these problems.

I think that what we have been sent by the Budget Committee is a Medicaid number that prevents good public policy from being arrived at, because I think what they have done is put the cart before the horse. They have put the cuts before we changed the policy.

They arrived at an arbitrary number and it says, you cut $182 billion over 7 years. We do not care how you do it, just go do it. That does not make a lot of sense to this Senator. We should look at public policy changes that produce savings, then add up the savings, and this is how much we have reached.

They just picked an arbitrary number and said, all right, go save $182 billion, and we do not care how you are going to do it. So I think what they have really done is put the cart before the horse. I mean, we should change public policy and figure out how much money we save by good policy changes and then add that up and that is the figure. They have gone about it, I think, backwards.

Medicaid, to my understanding, is growing at about 10.5 percent a year. They have said, let it grow 5 percent, and we do not know how you are going to do that. That is why it is so important for you to make those suggestions to us of how it is going to be done.

The concern I have is that a lot of people throw out magic words, we are going to managed care. Well, managed care is not going to get you 5 percent savings because managed care does not save that much when you are talking about the elderly. I mean, if you have a young, healthy population, managed care really works very well.

The statistics we have seen from some of the studies, I know in my State, long-term care, nursing home, home care, basically, for the elderly is about 37 percent of our budget. If you look at how much you save, the studies have shown, when you are talking about how much you are going to save from managed care in Medicaid, it says maybe about one or 2 percent.

So assuming we go to managed care and it really works wonderful things and we save one or 2 percent, how do you all get the other savings, I think, is the key question. This is not the formula, which I have some problems with, and all those things, but it is a question of, how do you get the savings, knowing that you are going to get less money?

I think a lot of Governors have really bought into the idea of block grants; it sounds great, it is wonderful, give us all the money. But what you are going to find when we give you that box is it is going to be a box full of problems and less money.

I think that is the real dilemma you are going to have in welfare reform, in Medicare, in Medicaid, and all these things that are getting ready to happen to you, and it is not with you. I think that is the big problem we have.

Any comments from any of you as to how you are going to go about making those savings? Mike?

Governor LEAVITT. Senator, I would say that you are not alone in worrying about the fact that all we have seen so far is the budget cut. Whether the cart is before the horse or not, let me just ask that you not forget to at least get to the other side. Our biggest worry in all of this is that that is all that will happen and that we will end up with the same program and fewer dollars.

Now, I have suggested that I believe we can get there. You have asked how. Let me just give you a couple, maybe three, suggestions. I mentioned one in my testimony. Anyone who says that there will not be people who will have different benefits than they have today in this process, I do not think is telling it exactly the way it is.

I have already suggested, we have negotiated with our low-income community to say we are prepared to take the dollar savings we can create from going from 130 percent of the average benefit package in our State to 118 percent and we will spread it over more people. That is one of the things we will end up doing, I am sure of that, in every State. Co-payments will be another. There will be some changes in the way we approach the benefit policy.

The second point is, I do not concur with the assessment, wherever it came from, with respect to the managed care. We are seeing much, much more significant savings in our State. If you go back to 1990, 1991, and 1992 we were running at 16, 13, 14 percent increases a year.

The last three fiscal years we have been down in the three and four percent range, this year 3.5 percent. The difference—the difference—is the fact that we have been converting, as rapidly as we can, now to a managed care environment. If you look at virtually every State in the country who has been given the capacity, even on a limited basis, to make that conversion, our success has been far more significant than——

Senator ROCKEFELLER. You see, that is one of the things that we are talking about. You have a young State, with a young population, and a lot of new people going in there. Lawton's State over there, with a lot of seniors, a lot of retired, you can throw managed care all over Florida and you are not going to get the same savings in his State that you are going to get in your State, but you are going to be frozen at the 1994 level.

Governor LEAVITT. Which leads me to the last point, and that is, there is no one in this committee room or in any State individually that knows the answer to your question. But the likelihood of us being able to figure it out, if we have 50 laboratories of democracy out learning how to do it, we are going to make some mistakes.

There are some folks in Oregon that are trying some things that I am darned glad they are doing and I do not have to. But I am going to learn from them. I am going to learn from them. We are doing some things in our State that they will learn from. They will make mistakes, we will make mistakes, we will all learn from each other's mistakes, but, most importantly, we will learn from each other's successes.

The possibility of ultimately solving this problem within the confines of that $180 billion rely on the capacity for us to go out and try it 100 different ways in 50 different places and be able to make it come——

Governor CHILES. I want to just say, I do not totally know the answer to your question; none of us do. But I can tell you, and I think I would like the Senate to share, that we ain't going to do it all with flexibility.

And I would like the Senate and the Congress to share that we are ultimately, if you say we are going to have $182 billion of savings, in Florida, going to cut people out of service. We are going to take people out of our nursing home care, we are going to cut some children off savings. I have already told you some of the things we have done in Florida. With the waiver that we have had now, we have taken care of the problem.

Mike says we can reduce our benefit package down to 100 percent of what the normal population is getting, and we will do all of those things and we can make some savings, some more than we are making, but we have already made a lot of them.

What we are looking at in Florida is, Kaiser is very conservative in what we think is going to happen in Florida. They have that we will lose 36,000 of our nursing home recipients; we think it is going to be higher than that.

I think the argument that we are just giving States flexibility, you can do that in the stroke of the pen. You can do that without cutting us $182 billion. We would all like that. And you can take some savings out of doing that, but you were right when you said we have come up with a figure and now you have told us to do it. We are going to cut a lot of people out of benefits.

Governor DEAN. May I make one point, Mr. Chairman? I apologize, because I know the Senator's time has expired. But we are talking about managed care here. I am a big fan of managed care. We want to get everybody into managed care. I just said, in response to Senator Graham's question, 50 percent of our budget is in long-term care, in nursing homes. Managed care does not touch that. It does not touch it. So no amount of managed care savings is going to help me deal with 50 percent of my budget.

Governor CHILES. 70 percent of mine.

Governor DEAN. We are in for some very tough sledding.

The other question I just wanted to very briefly respond to was something that Senator Pryor asked and Senator Chafee talked about this the last time I was here, and that is the question of, how much flexibility do we want? We want more flexibility.

We have talked about OBRA and we have talked about Boren, but when a mayor comes to me and says we want flexibility, I say, how much are we putting into this? You pay us, you have the right to call the tune. There are some things here that of national interest, and I am not somebody who believes we ought to be able to do anything we want.

There are some States who will not do it right. There are States who have applied for waivers which have been denied because they were not doing it right, because the numbers did not add up, because there was a lot of strife in the State about whether it was going to work or not.

Now, I agree also that waivers are too hard to get, but the fact is, there is a Federal role here somewhere. I do not think it is as big as the Federal role is today, but I do not think the Federal role is zero, either.

The CHAIRMAN. Before I call on Senator Moseley-Braun, Governor Leavitt made reference to the Oregon plan. What we tried—

we are into it and we will see how it works—is we extended Medicaid to 100 percent of the poverty level.

We covered single adults, we covered childless couples. But we also said at the same time, we just do not have enough public money to pay for everything for everybody, so there are some procedures we just will not pay for. We will not pay for the common cold anymore. We do not know how to cure the common cold, so we just took it off the list and said we are not going to pay for this anymore.

We have achieved about 70 percent in managed care. We have been into this program for almost 2 years. In one year we increased—which in Oregon is a big increase—the coverage by 120,000 people, which is about a 30 percent increase in 1 year. Cross your fingers, so far it is working.

Senator Moseley-Braun?

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman. I want to thank the Governors. This has been very helpful and a delightful discussion this morning over a very serious set of issues facing our country.

I am particularly delighted to see the Governor of my home State here. Governor Edgar and I go back to our days in the General Assembly together. I know that he cares about these issues, and hopefully we will be able to work together towards some kind of response and resolution.

I certainly agree, Governor Edgar, with your statement regarding flexibility. We need to give the States the ability to innovate. As the Governor from Utah, Governor Leavitt, mentioned, I think it is really important that we allow for innovation.

But the question becomes, how do you go about, in the context of that innovation, making certain that there are minimum standards, that there are standards and expectations, so that senior citizens, and children, and hospitals, and providers do not get hurt and the system does not fall apart altogether?

In our State, we have already tried innovation with the Healthy Moms, Healthy Kids program. It did not work very well. It is all right to go back to the drawing board, but I have a real concern that, in light of the fact that Illinois' budget has a $250 million reduction in Medicaid in FY 96. Also CBO analysis suggests there will be $1 billion less in Federal money. The State starts off with $1.4 billion in debt. So you basically start off with trying to innovate in the context of having less money. And, as my mother used to say, you cannot make a silk purse out of a sow's ear. It is difficult to try to do that.

I have a letter here from a lady in McComb, Illinois, Governor, who pleads that we do not end the entitlement status of Medicaid and go to the block grant formula because of her concerns about what is going to happen to her, her friends, and to the system overall.

She makes the point—and I am going to take my time to read this:

"A 75-year-old female friend receives $456 a month from Social Security. She spends over a fourth of this on medication. She has congestive heart disease, high blood pressure, arthritis, and interstitial cystitis.

"She is recovering from a broken hip in March, and compression fracture of a vertebra in April. She is very proud and will do without medicine if the month lasts longer than her money. She barely survives now. I cannot imagine what would happen if her benefits were decreased. She is a widow with no children and no other family support."

Then this lady in McComb says, "Do not make Medicaid a block grant program and do not make slashes in services by imposing severe cuts."

Now, in your statement you make reference to the notion that States cannot limit access to health care providers as a means to negotiate the best possible rates. I mean, how do you balance? You have got less money to work with, the problems remain constant, the State is already in debt. In the absence of minimum standards, how do we tell this lady in McComb that her 75-year-old friend will not be just left out with no protection?

Governor EDGAR. First of all, on standards, I do not think anyone is suggesting that I have heard from the Governors that this money would be taken, what we get from the Federal Government in block grants, and be used to build highways and other things. There has been that accusation in the past.

Under the current program some States maybe have used money for other things or have been able to free up dollars. I am not suggesting that. I think we ought to put the money we receive from the block grants into health care for the poor. I think there has been a fear out there on the part of some that we would take this money—and I have heard it today—and go out and spend it on other things.

I can assure you, in Illinois our concern would be to take care of the poor. But to be able to again go back, Senator, and be able to negotiate good rates, private insurers can do that now. They can negotiate. We cannot negotiate. We are at the mercy of the providers, in most cases, because they can go through the Boren Amendment.

I am not sure why this lady believes that a block grant will threaten that. I think there has been the implication that block grants means we are going to slash a lot of programs. I do not think that is true. I think the block grants will allow us to set the priorities that people think are the right priorities.

Let me go back to another question, and this has been kind of a question that has come up that we have not addressed, is how do we know you are going to spend the money the right way, or how do we know you are going to take care of the people who truly have needs.

I guess I go back to the democratic process. We are all elected. Just like you are elected, I am elected by the same voters. And I think the people in our State are going to demand certain priorities, and I really believe Governors and State legislators are just as cognizant of those priorities as people in Washington, particularly people who are not elected in Washington who very often have the final say on these programs.

So, to the lady in McComb, I would just assure her, we are going to take care of the people in Illinois who are truly needy.

We would like to be given the ability to manage those programs and set the policy, not someone in Washington who may not understand the problems of McComb, Illinois, or Chicago, or Charleston, or wherever. I really think there is a lot of fear that has been raised about block grants that I do not think is valid.

Now, as Governor Leavitt mentioned, there are going to be some attempts that are not going to work. You mentioned Healthy Moms, Healthy Kids. In Chicago it did not work; it has worked well down State.

But it as an attempt to try to solve a problem that we knew was there and we are going to make some mistakes along the way. But I do not think you can say, well, States, you should not even try, you should not be given the ability to do that. That is really what I think the block grant is all about, giving us the ability to try those things.

Senator MOSELEY-BRAUN. So am I understanding your answer to say that you think there ought to be minimum standards?

Governor EDGAR. I think there ought to be assurance that the money that we have in the block grants will go to take care of the needy. There has been the implication, here and other places, that perhaps we are going to take this money and spend it on some other program, like building prisons, or whatever. I do not see that at all. I do not think anyone has suggested that, that I have heard.

Senator MOSELEY-BRAUN. Well, our legislation does not have minimum standards or requirements. Would you suggest that we change it and amend it in that regard?

Governor EDGAR. I do not think the legislation would allow us—again, I do not know if we have seen any specific legislation. You talk about the budget resolution. I do not think we have seen a specific bill yet on how all these things are going to be done. I think that is part of what you are going to develop here in this committee.

Senator MOSELEY-BRAUN. That is correct.

Governor EDGAR. I would say that you ought to have an assurance that the money that would go for block grants for Medicaid would be spent for the needy, not go to build highways, or build prisons, or whatever.

Senator MOSELEY-BRAUN. Thank you.

Can I ask one other question?

The CHAIRMAN. As a matter of fact, I do not know anybody who is even talking about block grants that says it is unlimited and you can use it for airport tarmacs or whatever else you want to use it for. In the broadest of definitions it might say "medical expenses for the needy," or something like that.

Beyond that, how far you want to get into parsing it and putting in regulations, I do not want to. But this is not going to be like the old general revenue sharing where you just get the money and off you go with it.

Governor CHILES. Mr. Chairman, I would point out one thing in that, though, that assuming that the money comes down, you cannot just switch these dollars. Remember, we are talking about a program in which the State has put up 40–45 percent of the money, and the Federal Government. Now it is going to be just the

Federal Government's share, with no requirement for the State to match. So if you do not put some standards in there——

Senator MOYNIHAN. A maintenance of effort.

Governor CHILES. Pardon?

Senator MOYNIHAN. A maintenance of effort.

Senator MOSELEY-BRAUN. A maintenance of effort. That is right.

Senator MOYNIHAN. Maintenance of effort.

Governor CHILES. Maintenance of effort. That is right. Maintenance of effort, or that you are saying that there are certain standards. I would say both ways, because then, in effect, you might say that that money is going for highways, is going for there.

The other thing I would just say is, I think we have to go back into the history of this a little bit, of how these programs came out. It was the Federal Government that hung the carrot out and said, if you will cover women up to 185 percent then we will provide this money.

It was the Federal Government that said to start with in all of these programs. And if you go back and look at our States and where we were before any of these programs start and then say you totally trust the State, the Governors, and the legislature to take care of all these things, we were not doing it. It was not being done.

I would just say to you, these are Federal taxpayers' dollars that you are talking about giving us, and you have some responsibility to see that they are spent properly.

I believe the Federal Government still has a role. I would hate to see you divorce yourself from the role of saying you are concerned about taking care of kids, you are concerned about the elderly. You are going to run for that, I believe, at some stage, but you should express that you really mean that.

The CHAIRMAN. When Governor Edgar was testifying I turned over to Senator Moynihan. I said, it is an interesting philosophical difference and it is fun to have this kind of a debate. When I posed the question to you, what if you had a total block grant with no strings and enough money, you said, no, you would still want some minimum qualifications.

Then Governor Edgar says, apart from spending it on the needy, we all run for election, we all have the same constituencies, we all have the same pressures, and we are going to take care of the needy. But you used an expression a lot, it is Federal money. Legally, you are right. The court would say, yes, this is Federal money. We really just kind of have it in trust for awhile and then parcel it out.

The real question is not is it Federal money, but is it better Federal policy? You can still call it Federal money, but give the money to the States and say, you manage it, because we think you can manage it better than we can. That can still be a perfectly legitimate trust arrangement.

Governor DEAN. Senator, it can be.

Governor CHILES. Trust plus verification, someone once said.

Governor DEAN. That is right. Trust and verify. I think that was Ronald Reagan.

Here is the problem. What is going to happen is, human beings being what they are, things do not go well in the Federal Government, we need to change the system, we all agree we need more flexibility, some State is going to make a mistake, whether it is my State, or any of the States here, or somebody else.

There is going to be a big scandal and dollars are going to go where they are not supposed to go. Human beings do things. Government people do not all get it right, whether they are at the State level or the Federal Government. Then there is going to be a big cry to fix this, because people will be kicked off the rolls, people will not get care, die, whatever. The papers will make a big deal of it; you know how it goes.

So I think that we can, perhaps, instead of going all the way from one extreme to another, find a middle road. What I am suggesting today is, you can solve a problem that you are going to have as the Chairman, which is going to be the States' share crisis with an entitlement cap instead of a block grant, you can put some of the strings on us that I know Senator Chafee and Senator Pryor have talked about, but give us some more flexibility and meet the criteria that you and many of your colleagues want to meet, which is to allow States to be able to do more things and have less Federal interference, and so forth, and so on.

So I guess I would say, as a Governor and not as the Chair of NGA, although I frequently make this pitch to my colleagues, sometimes without great result and sometimes with a little more result, is that there is a middle way here.

We need to cut the budget. We have to take the hit for that as Governors, and we know we have to do our share, but that we do not want to reduce the number of people who are getting some care, even though we know we are going to have to reduce benefits, and that there is still a partnership between the Federal Government and there is a national interest in children and in taking care of people.

We are not just talking about needy people on welfare, we are talking about working people. A lot of Medicaid dollars goes to pay for working people. We just got a waiver to expand it so that more farmers and loggers making $10,000 a year can get health insurance which they cannot now get.

So, in conclusion, at least for myself, I would just say, if the committee could find a middle way here which gave us more flexibility, which maintained some Federal oversight, which shared the costs—and I think the capped entitlement is the way to do it because you do avoid the growth versus no growth fight—I think the country is, in the long-run, going to be better off, because I am quite convinced that if we do adopt the provisions that appear to be heading down the track with $182 billion of cuts and block grants, that we will be back here four or 5 years from now trying to figure out what to do about State X, which really is not doing the kinds of things that most people in the country think they ought to be doing, or even that most people in that particular State ought to be doing.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Thank you, Mr. Chairman. Thank the Governors very much.

The CHAIRMAN. Senator Graham?

Senator GRAHAM. Mr. Chairman, I would like to ask a couple of questions to each of the Governors.

In 1981, Lawton was sitting over here and I was sitting where Lawton is. In 1981, we were into a period called New Federalism. President Reagan, at that time, had a concept of reallocation of programs as between the States and the Federal Government, but he had some concepts behind that reallocation.

One of those concepts was that the Federal Government should be primarily responsible for those programs that caused mobility within the population, programs that dealt with a transitory population should be dealt with at the Federal level, programs that were more geographically fixed ought to be increasingly a State responsibility. So, for instance, he would advocate that transportation ought to be more of a State responsibility and that Medicaid should be even more of a Federal responsibility.

We now seem to have reversed that. There is no discussion about turning transportation over to the States and reducing Federal levels of expenditure on that, specifically on highway programs, yet the mobility programs—Medicaid, as an example, welfare as another—are exactly the programs that are going to go back to the States.

Would you agree with President Reagan in 1981, or with the philosophy of 1995 as to which sets of programs would be most appropriate for return to the States?

Governor EDGAR. Well, I think an awful lot of this debate today has been driven, not just on those issues, but it has been driven by, how do we balance the budget?

Senator GRAHAM. Well, yes. You can balance the budget either way. In other words, you can select a set of programs that would be what President Reagan would refer to as the State-bound program, and have the Federal Government retreat from its level of support of that.

We are spending $20–25 billion a year on transportation. That could be turned back to the States while the Federal Government continued its involvement in these mobility programs. So, we can achieve the goal of balancing the Federal budget in a variety of ways. None of this is Biblical.

The question is, as four Governors, which sets of programs do you think would be the most appropriate for greater State responsibility and which sets of programs should continue to have a significant level of Federal involvement?

Governor LEAVITT. Senator, there is an assumption that, because there may be differences in benefits between States that it would create a mobility. That is an assumption, I think, that is now challengeable on the basis of just what has occurred. There is a substantial difference in benefits, both on welfare and on Medicaid, from State to State.

Although there is designed to be some levels of standards, there are differences. There has not occurred, at least that I am aware of being documented, a major flight from Mississippi to Vermont, and there are dramatic differences in the levels of welfare benefits, for example, that they receive.

So if that were the basis under which the early Federalism arguments were being made in the 1980's, and you know that is an issue on which I have some interest, I do not think that was a proper assumption.

Senator GRAHAM. So your answer is, you would rather have the Federal Government continue with its current level of support of highways and let the States have more of the responsibility for welfare and health-related programs.

Governor LEAVITT. Well, I think you can make an argument, and you have given me this opening, to say that we have basically finished the interstate highway system, and my preference would be to have them out of both. I cannot see, particularly on the highways, how the national government is adding to that process a great deal. My preference would be to have them out of both.

Senator GRAHAM. Governor Edgar?

Governor EDGAR. Well, I am trying to do a quick calculation money-wise on where we come out the best, which would probably be the first thing Governors would honestly do. I guess there have been discussions in the past about Federal Government taking over Medicaid. In fact, I understood back in the early 1980's—and I was not privy to those discussions—there was the concept that Federal Government take over Medicaid and the States do all education. Apparently some Governor said no to that. I would like to find that person and have a chat with him. But I would not be opposed, but I do not think it is going to happen, if the Federal Government would take over Medicaid.

I guess the frustration I have right now is, we are responsible to run the program but we cannot set the policy. It is pretty well controlled here, and that is the worst of both worlds. So if I am going to have to run it, let me be able at least to try to set the policies to run it well, not to say you are in charge of it but somebody else is pulling the strings.

Senator GRAHAM. Governor Dean?

Governor DEAN. Let me just first take a moment. Apparently I have run afoul of Washington-ese and I have been using the word "capped entitlement" instead of "per capita cap," and there is a difference.

The CHAIRMAN. Oh, yes.

Governor DEAN. Capped entitlement does nothing to help you out of your jam in terms of high-growth States and low-growth States because it functions exactly like a block grant. Per capita cap does. What that does is allow for growth and allow for a capping of what you spend on the individual, which solves your growth problem. That is really what I have been talking about when I use the phrase "capped entitlement."

The CHAIRMAN. Yes. We give you $100 a person, no matter how many people, is a capped entitlement.

Governor DEAN. That is correct. That is correct.

The CHAIRMAN. Yes. All right.

Governor DEAN. That solves the growth problem and gives us a little bit of flexibility.

In answer to Senator Graham's question, there is no easy answer. You have to look at it in a broad framework. The framework that I use is, what is in the national interest and what ought to be left up to the States? It is a State matter whether my secondary roads and bridges are a wreck or not, and it is up to me whether

I am going to be stupid enough to let them get wrecked and ruin my business climate or whether I am going to make some investment in it.

But the Nation has an interest in maintaining a strong interstate system and, therefore the current arrangement is not unreasonable, particularly after Ice Tea passed. Ice Tea was a revolution for us because we now can spend Federal money doing other things.

So I think you could look at that formula, but in the long run you have to conclude that the interstate system has to somehow be maintained by the feds, however you care to make that arrangement, and then we could be responsible for the rest of it. We should probably should be given back the gas tax capacity to do that.

On Medicaid and welfare, again, I believe there is a national interest in children. The School Lunch program, which I have been so incensed and adamant about, for example, was started in 1946 because kids were not passing physicals when they were coming out of high schools when they were going into the Army.

There was a national interest in making sure that every child, from Mississippi, to Vermont, to Chicago, to California is well-nourished and able to learn in school. So, hence, I am a very strong supporter of Federal programs for school nutrition. They happen to work very well as well.

If I were designing it, starting from scratch with no political overlay about block grants, entitlements, and so forth, I would probably design a medical program where all kids were covered by the Federal Government and the States had to figure out what to do about everybody else. That is what I would do.

Now, that is not on the table here and I am not foolish enough to think you are suddenly going to throw everything up in the air and change it. But there is a national interest. You all have to decide what it is in. That debate is going to change when we come out of this session, no matter who prevails on what. There is going to be less that is found to be in the national interest than has by previous Congresses.

I think that is a good thing as a Governor, even as a Democratic Governor. But what I do not want to do is go far that we start saying that certain things that I strongly believe are in the national interest are no longer in the national interest. So I think in tone you get an agreement here. I think our disagreements are in how far to go, and the democratic process is the only process to resolve that.

Senator GRAHAM. Governor Chiles?

Governor CHILES. I think it is an interesting question that you pose to us, and it is very interesting that the highway program is not on the table. It is a popular program and I think that that is one of the reasons it is not on the table.

I would tell you that Florida would sacrifice, we would give you Medicaid and you give us highways. We would be happy to make that sacrifice. But, at the same time, I would tell you that Florida would administer the Medicaid program much better than the Federal Government would do it, so I think the States ought to be responsible for that.

But we would love to have the highway program and let the Federal Government just say to the people, we are not going to tax you on highways, and we would fill that void from the State level and we would have a heck of a lot more dollars in my State than we have now because we are a debtor to the highway program.

But I think it is an interesting thing to say, you know, if highways are so important that the Federal Government is going to keep control of them, then certainly requiring some minimum benefits, or standards, or however we want to term this, children ought to be important to the Federal Government, I would think.

Governor LEAVITT. Senator Graham, could I make just one comment? I wish this could be a Federalism debate and not conducted as though it were a discussion on the out-sourcing of the administration of a national program. I think it is a very valid point that you have raised.

The CHAIRMAN. I might tell you, Bob, every now and then there is humor in this business. I will not say which paper it was, but about a month ago a young reporter called me asking this very question about mobility in welfare, and did I not think that if we went to block grants people would move from low benefit States to high benefit States?

I said, well, I just read an article in your paper two weeks ago quoting a study, and I had it around on my desk someplace, that says there is just no evidence for that, that maybe politicians believe that, but there is no evidence. I searched around my papers and pulled it out, and it was by the reporter who was calling me. [Laughter.]

The CHAIRMAN. Then something like that happens.

Senator Moseley-Braun.

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman. You are right when you raise the issue about the philosophical question here. I think that the issue of national interest and what can be appropriately done at the State level and the national level, the arrangement, if you will, for the partnership that some of the Governors have talked about, I think that is really the critical issue that we have to define here.

Certainly the Governor in any State is going to be concerned about what happens to the children and the people who live in that State, but then I think the people in the rest of the country, all of us, are in this together and we all have a concern, just as you, Governor Leavitt, would be concerned about the lady in McComb, Illinois and Governor Chiles would be concerned about Children's Hospitals in Chicago.

I mean, we all have an interest in seeing to it that the system, whatever it is we construct, is a cooperative one that can work to provide for the people that we are all elected to serve. I think we can agree on that.

I have a concern, again, coming back to the dollars, how you are going to be able to do what it is that I think the Governors have in their minds to do with fewer dollars. The fact is, we have a formula in place with Medicaid that has been in place since 1965 that burdens some States and benefits others, that sets up a competition among the States, on the one hand.

Again, as I mentioned to my Governor, Governor Edgar, when we were in the first round, most States will have fewer dollars to work with. And there is this phenomenon of hospitals closing and threatening to close because they are not getting paid and they cannot get paid because the Governors are already trying to juggle and balance and make do with what little they have to work with.

I just wonder, to what extent are we not kind of begging the question and maybe buying a problem for ourselves with the Governors of the States who say they want block grants and they want this authority, could this not be a little bit like having eyes too big for your stomach, that is to say, biting off more than you can chew?

You are going to have the same level of problem, you are not going to have the same financial support, you are going to have the expectations raised in terms of your ability to innovate, but you are still kind of mired in with fewer dollars than may be necessary to take care of the people in your State, particularly the children and the elderly.

In our own State, again, the formula that is in place now for Medicaid penalizes States like Illinois that have more children. I would imagine, I do not know your State comes out, Governor Leavitt, but certainly it is a high-growth State so you would be penalized by the current formula. I know our State is.

Would it make sense to you, and I put this question to the Governors, to have an allocation formula based on the number of children who are in need of health services in the system or some other formula of distribution than currently is in place?

Governor DEAN. Well, the current formula is really similar to that. What you are saying sounds to me like something I understand that Senator Dole has privately talked about, which is some kind of an entitlement for kids, which I think is a step in the right direction. We currently have under the current system a system which allocates money to the States based on population in need. That is what the entitlement is.

What I am saying is, if you need to meet a budget target you cap the amount that each person can use and that is how you get to your budget figure, although I think most people understand that you probably cannot get to $182 billion using that technique, but you can certainly make some significant savings.

What you are suggesting would actually be a retreat from where we are now, but it also would be a compromise from where we might be should the proposal pass tomorrow and then that number be adhered to in the final reconciliation bill.

So I certainly think that if that were put forward that it would be a step towards the middle, and perhaps that is something we ought to take seriously. There is certainly no NGA position on that, but I would be interested in how other Governors might respond.

Governor LEAVITT. I would be happy to respond. This whole formula debate boils down to this. I live in a State of Utah with 19 percent growth over 10 years. Look at the State of New York, which is projected during the same period to have a quarter of 1 percent decline.

I am not at all enthusiastic about a formula that says we are going to use this as the base year and just split the money up for 5–7 years on that basis because I lose my 19 percent and they gain, particularly since I have been doing what I think is aggressively bringing my Medicaid growth down. Whether they have or not I do not know, but look at their numbers and they will tell you.

Even if we had any kind of formula, if I have a 19 percent increase in the number of people in my State, they are not all going to be on Medicaid. I hope they are all serving in high-paying jobs that have great benefit packages. That is our goal.

So what I am suggesting is, I do not know how big my Medicaid population is going to be or how much of that 19 percent is going to be on Medicaid, or on welfare, or on anything else. Some formula that actually goes to where the needs are makes more sense to me than simply saying, let us arbitrarily cap it and go forward for the next five years, or let us just go by population growth and I ought to get 19 percent more in 10 years. That does not make any more sense to me than the former case.

What you are saying makes good sense to me. It may be that there has to be a number of factors, but it ought to be based on actual need apportioned among the available dollars as opposed to something arbitrary at the beginning.

Senator MOSELEY-BRAUN. Thank you.

The CHAIRMAN. Any more, Bob?

Senator GRAHAM. I would like to ask one last question of each of the four Governors.

The CHAIRMAN. Go ahead.

Senator MOSELEY-BRAUN. Hold your thought, Bob.

Governor Edgar, would you respond to that, because I think it really is important for Illinois.

Governor EDGAR. Well, I think, first of all, there has been a lot of discussion about, growth ought to be a factor. I can appreciate States that are growing very fast, they want that as a factor. I am not crazy about the current formula. We get 50 cents on every dollar; some States get 75 cents on every dollar spent on Medicaid.

There are a lot of things in the current formula that I would question. I think anytime you put together a change in that formula there is going to be a lot of give and take. I think we have already heard, there is concern from some States on growth.

I have got a concern on the fact that we are so called a wealthy State so we only get 50 cents on a dollar, where some States get 75 cents on a dollar. I think all those things would have to be taken into consideration when you look at how you are going to distribute these dollars.

That is not going to be easy because you have got X number of dollars in the pie and anytime you change that formula some States are going to win and some are going to lose. It is like the old days of the school aid formula. I mean, it made it very difficult.

Nobody liked the formula, but you could never get enough people to agree on a change because you had winners and losers. But I am not opposed to taking a look at how we distribute the dollars and take all these things into consideration.

I think the key is going to be, the practical political problem is, how do you come up with something that you can get basically 30 States to agree on so you have 60 votes in the Senate if you are going to make a change there.

Senator MOSELEY-BRAUN. Well, I think that gets, though, to another part of this philosophical debate, whether we are talking about entitlement to the States or an entitlement to children, entitlement to poor people, or to sick people, or however we are going to define it.

I mean, is this an entitlement to people or is it an entitlement to States? If it is an entitlement to people then I think we can look at formula revision in a sensible kind of way as opposed to the kind of allocation that we have right now.

Governor EDGAR. If it is entitlement to individuals and you are talking even about what the President is talking about as a level, then I think all States have problems dealing with trying to manage it. I mean, one of the problems here is that entitlements are great. The problem is, it takes away our ability to manage——

Senator MOSELEY-BRAUN. The word "entitlement" is problematic and I wish that we could come up with another one. Guarantee to children. Let's try that one.

Governor EDGAR. I mean, again, I will go back, Senator, I think, to suggest that it takes the Federal Government to protect children, that State-elected officials are not sensitive to children, I just do not agree with that.

Senator MOSELEY-BRAUN. That is not the suggestion. That is not the suggestion. Thank you very much.

I am sorry. Thank you very much for your indulgence, Senator Graham.

Senator GRAHAM. I would like to ask each of the Governors this question, which has two assumptions behind it. First, is that you will be provided the range of flexibility that you hope to achieve through a block grant, and, second, that your funding level will be predicated on the House-Senate Budget Conference.

With those two assumptions in mind, do you believe that over the next 5 years you will be able to provide to your Medicaid population the same quality of health care to the same proportion of that population as you are currently doing?

Governor DEAN. Absolutely not. There is no possible way.

Senator GRAHAM. Governor Edgar?

Governor EDGAR. Well, I think we can provide adequate care with that flexibility. It is something, also, to my understanding, that it is going to ratchet down. It is not going to be automatically next year four percent, but it comes down. I think we can provide adequately.

Does that mean there may not be some cuts in some benefits? There will be, as has been stated by Governor Leavitt, and I know in our own State there are many cases where Medicaid benefits are better than what most people out in the private sector have, so I think we can provide adequate coverage. Undoubtedly there will be some cuts in benefits, but I do not think those cuts will be to the point where you deny adequate care to this individuals.

Senator GRAHAM. Governor Leavitt?

Governor LEAVITT. I believe, given the flexibility, we can provide basic health care to our citizens.

Senator GRAHAM. The question is, could you provide the same quality of care and to the same proportion of your population that you currently do.

Governor LEAVITT. In many cases, I think it will be better quality because part of this whole process has to be, how do you use the quality piece to both reduce the amount of health care dollars that go into the system? Ultimately what you have to do is keep people healthy. If you can keep people healthy, your health costs are going to go down.

You have asked a question that I have already stated, people in our State are likely, by negotiation—we have already put a proposal on the table—we would like to reduce some areas of benefit to provide more for everybody, to have everyone have something.

Senator GRAHAM. Excuse me, Mr. Chairman. Let me ask one more question.

The CHAIRMAN. Go right ahead.

Senator GRAHAM. I might say, this comes out of my prejudice in having performance standards by which you can measure what actually happened. If we were having this hearing 5 years from now and, in fact, the current program was adopted, it had 5 years to run, what would be some of the performance standards that you would want to be able to look to to answer the question, has there been a change in the quality of health care services to the Medicaid population?

Governor Dean has the additional advantage of being a physician, so he might be able to start with suggesting, what would be some of those performance standards?

Governor DEAN. Probably the first one I would look at is just standard morbidity and mortality figures, but I would certainly look at percent of kids who are immunized at age two, percentage of your population per age group in a nursing home, in institutional care, and then I would look at a number of cost factors, how much we are spending on what.

There is a huge and very sophisticated and complicated matrix of who gets what kind of health services which is available and is capable of being done on a national level. Those are all things I would look at in terms of how well we are using our resources.

But I think probably it is more difficult to measure other things which are important, the percentage of children in poverty, percentage of children who are ready to learn. Those are all much more subjective and more difficult. But the first one I would look at is immunization rates for 2-year-old children, and go from there.

Senator GRAHAM. Governor Edgar?

Governor EDGAR. What Governor Dean outlined are very valid things to look at. I think, maybe to go back to your original thesis, is I think it is justifiable that there ought to be some kind of review. Again, that is part of the concern, perhaps, that States may not do what they should do.

I think if there is a review, not a Federal requirement to meet, but if there is a review done by a respected body to compare the States and then each State would have to explain why maybe they do not compare as well as other States when it comes to immunization or various categories. They are going to have to explain that to their constituents.

I think that would be a safeguard that could be placed in this program without tying our hands, but something we know we are going to have to answer to. I do not have any problem with that. In fact, I think that would be something that is justifiable.

Senator GRAHAM. Governor Leavitt?

Governor LEAVITT. Senator, this is a question that occupies a substantial amount of discussion in my State right now, how do you define quality? I had a conversation with a group of journalists 1 day about, how do you define quality in education, and that is a tough one, too. A journalist said, I think a quality education really is when you get to hang out with a lot of smart people.

Well, that is not a number and it is hard to hold people accountable, but it is probably a pretty good statement. Now, in health care we are putting together a quality system where we are establishing standards and then a set of reporting requirements for all of the institutions that are involved in health care, hospitals, doctors, and so forth so that we can actually start drawing conclusions from it. Governor Dean obviously is in a position to enumerate some of them. I am not sure it is a simple answer. I am not sure it is one you can say, here are five points we want you to meet.

I know if you do that you will drive the whole system because everybody will be working to make certain that they, at all costs, get immunization, and that is how we end up with a lot of prescription, is that people want to say, well, let us achieve standards, and then it drives the whole system. I do not know that you can define, in four or five standards, how you measure quality.

Senator GRAHAM. Governor Chiles, I had asked two questions. One, is assuming that flexibility associated with a block grant was available and that money that will flow will be that which is anticipated under the current House-Senate Budget Conference, under the $182 billion reduction, do you believe in your State that you will be able to maintain, over the next 5 years, the current level of quality of health care being provided to the same proportion of your State's population that you are currently doing under the Medicaid system?

Governor CHILES. I do not think we will in Florida because I think that we have already sort of taken out some of the slack. We have gone a lot to managed care. We have already begun to restrain our costs a lot. Under the current dollar formulas that you are taking I think that either the State will end up having to raise revenue, put in more money to the program, or we will have to cut a number of the benefits. I think we would suffer.

We will do things like cost-sharing, certainly. We are already working to go into those regards. But to maintain the current level of services to the current people we are now providing it for, I do not think we will be able to do it. The other question, I think you asked something on——

Senator GRAHAM. The other question was——

Governor CHILES. I would hope that there would be some kind of a report card, at a minimum. And if there were some standards developed, we would think that would be good.

Senator GRAHAM. Thank you, Mr. Chairman.

The CHAIRMAN. Gentlemen, thank you. We are adjourned.

[Whereupon, at 1:05 p.m. the hearing was recessed, to reconvene at 9:30 a.m. on Thursday, June 29, 1995.]

MEDICAID: HISTORICAL OVERVIEW

THURSDAY, JUNE 29, 1995

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to recess, at 9:30 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman of the committee) presiding.

Also present: Senators Grassley, Simpson, D'Amato, Moynihan, Rockefeller, and Graham.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The Committee will please come to order.

I will tell you what I think happened. There has been a long delay. There she is. Gail, I do not know if you got caught going through the metal detectors downstairs. I understand that it was a long line. But we are all here now, three people as expert in the subject we are dealing with as we are likely to have.

This is the second in a continuing series of hearings on Medicaid, looking at the assumption that we are going to try to meet the totals that the budget resolution, which will be adopted later today, will give us to meet.

So any direction you can give us, or advice that you can give us, will be appreciated.

We will start with our new Budget Director, Dr. June O'Neill.

Doctor?

STATEMENT OF JUNE E. O'NEILL, PH.D., DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. O'NEILL. Mr. Chairman, it is my pleasure to be here today to discuss the status of the Medicaid program.

If I may, I will summarize my testimony and submit my full statement for the record.

I will emphasize three points:

First, Medicaid spending has increased at unsustainable rates over the past decade.

Second, although growth in Medicaid spending will slow somewhat over the next decade, it is likely to remain extremely rapid unless significant policy actions are taken to restrain that growth.

Third, choosing an appropriate course of action will not be easy. It may be necessary to restructure Medicaid substantially to satisfy the savings requirements assumed in the conference report on the budget resolution.

Medicaid is a unique health program, providing both acute medical services and long-term care to a low-income, but highly heterogeneous population. It is jointly funded by the Federal Government and the States. The Federal share varies from about 50 to 80 percent.

However, Medicaid is administered by the States which, though subject to Federal guidelines, retain considerable discretion over all aspects of program operation.

This year, Federal Medicaid spending is expected to reach $89 billion, which amounts to 6 percent of the Federal budget. Total spending, including the State share, is expected to be about $156 billion.

Medicaid spending has escalated sharply in recent years. Between 1988 and 1993, overall Medicaid spending increased at an annual rate of 16 percent, while the Federal share increased at a remarkable 20 percent per year. Yet, over the same period, national health expenditures rose by less than 10 percent a year.

Before 1988, Medicaid typically grew at about the same rate as national health expenditures. The two most significant factors contributing to Medicaid's dramatic growth between 1988 and 1993 were sharp increases in Medicaid enrollment and the development of State financing schemes, which increased disproportionate share payments.

Between 1988 and 1993, the number of Medicaid beneficiaries grew by almost 50 percent. Some of this growth was caused by the rapid increase in the Aid to Families with Dependent Children (AFDC) caseload in those years, but much of the growth was related to the mandatory and optional expansions in Medicaid eligibility authorized by the Congress between 1984 and 1990, which focused on low-income children and pregnant women.

As a result of those expansions, the number of children on Medicaid rose from 10 million in 1988 to 16 million in 1993. The 1990 expansion of coverage to all poor children will continue to add new beneficiaries over the next seven years, although the cost impact of that expansion will not be great.

The number of disabled Medicaid beneficiaries also expanded rapidly, rising from 3.5 million in 1988 to 5 million in 1993, while expenditures on the disabled doubled. Several court decisions liberalized the definition of disability and allowed for a dramatic increase in the number of mentally impaired and disabled children eligible for coverage. This drove up the costs of both Medicaid and the Supplemental Security Income (SSI) program.

State financing schemes were even more important than eligibility expansions in spurring growth in Federal Medicaid spending in recent years. Those schemes, which involved voluntary donations from providers, taxes on providers, and intergovernmental transfers, drew down Federal matching dollars for what were often illusory Medicaid expenditures. Disproportionate share, or DSH, payments rose from $1 billion in 1990 to $17 billion in 1992 because of those arrangements.

With respect to the future, the Congressional Budget Office projects that under current policy—that is, the CBO baseline—the

Federal share of Medicaid payments will rise from $89 billion in 1995 to $232 billion in 2005. This represents an average annual rate of growth of about 10 percent.

By contrast, OMB's projections assume a growth rate that is about 1 percentage point lower. The 10 percent growth rate that we project over the next decade is slower than that of recent years, but it is still a very rapid rate. On the basis of CBO's assumptions, Federal Medicaid expenditures would double by 2002. Even by the more optimistic Office of Management and Budget (OMB) assumptions, Federal Medicaid spending would double, but by 2003.

Of course, projections of spending are always made with uncertainty, and this is particularly true in the case of Medicaid, which involves the determination of future behavior of all the States.

Lacking a crystal ball, we cannot be sure which States will successfully pursue cost-saving measures, and which States will act to expand eligibility and services and, on balance, add to costs.

Many States are moving quickly to enroll Medicaid recipients in managed care plans that have proven to be cost-saving for children and adults who are neither elderly nor disabled. But managed care for the disabled and elderly population is relatively new; therefore, the outcomes are more difficult to predict.

The conference agreement on the budget resolution for fiscal year 1996 assumes that the Federal share of Medicaid spending would increase from $89 billion in 1995 to $124 billion in 2002. The average annual rate of growth assumed over those years would then be 4.8 percent, which is well below the 10 percent growth rate that CBO projects under current policy.

Reducing the average annual rate of Medicaid expenditures over the next seven years to 4.8 percent will not be easy. To assess the difficulty, it may be helpful to consider the resources that would be required simply to maintain program participation and medical services at their present levels, ignoring the increases in participation and improvements in services that are expected to occur under current law and policy.

The ingredients needed to make such a calculation include expected increases in the population and purely inflationary increases in the price of services.

The annual growth rate in the population under the age of 18 and over the age of 65 is expected to grow at an average annual rate below 1 percent over the coming decade, which is a slowdown from the 1980s.

The increase in the number of disabled individuals is more difficult to estimate, but it is likely to exceed 1 percent a year.

Pure medical inflation is difficult to measure, but can be approximated by the growth in compensation per hour, in nominal terms. That growth rate is expected to be 3.7 percent a year.

A 4.8 percent growth rate might be sufficient to maintain Medicaid at the present levels of population participation; that is, just allowing for increases in the population, but maintaining the same participation rates as at present, and maintaining services at the same level as they are now. But it will be a close fit.

Thus, meeting the target growth rate would probably imply limitations on the extension of Medicaid eligibility to new groups, and on further expansion of the quality of services provided, unless the

States increased expenditures on the Medicaid population with their own funds. Improvements in the efficiency with which Medicaid is operated, however, could help to stretch resources.

The Congress could consider a number of policy changes to achieve the budget resolution's assumed spending levels for Medicaid.

Programmatic policies could alter eligibility rules for enrollment, or reduce the services covered by the program.

Financial policies could alter the way in which the Federal Government pays for Medicaid—for example, by reducing the Federal matching formula or imposing caps on Federal matching payments. An even greater departure from the current system would convert Medicaid into a block grant to the States.

As a budgeting tool, block grants offer a much more certain way for the Federal Government to control the level of expenditures. And block grants would probably give the States greater flexibility and the incentive to improve efficiency.

But block grants are likely to raise a number of other concerns.

The CHAIRMAN. I am going to have to ask you to wind down, doctor.

Dr. O'NEILL. Yes, I am. Another minute or less.

With tightening fiscal constraints, would the States allow adverse impacts on access to care or the quality of care? Could the Federal Government retain a role in assuring access and quality, and still allow the States the flexibility they desire?

The allocation of Federal funds among the States will surely be of paramount concern. Both the initial distribution of block grant funds among the States, and how these amounts should grow over time, raise difficult policy questions.

In conclusion, many of the nation's Governors are now seeking less Federal control of the Medicaid program in order to enable the States to meet the health care needs of their low-income populations. The desire of the States for greater flexibility, plus the intent of the Congress to reduce significantly the rate of growth in Federal Medicaid spending, make the program ripe for change.

How to limit program growth in an appropriate way is the challenge facing the Congress and the States.

Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Dr. O'Neill appears in the appendix.]

And, second, we will take Dr. Diane Rowland, who is the senior vice president of the Henry J. Kaiser Family Foundation, and the executive director of the Kaiser Commission on the Future of Medicaid.

She is someone well known in Congress. She served on Henry Waxman's staff, responsible for this subject I believe, for a good many years.

STATEMENT OF DIANE ROWLAND, Sc.D., EXECUTIVE DIRECTOR, KAISER COMMISSION ON THE FUTURE OF MEDICAID, WASHINGTON, DC

Dr. ROWLAND. Thank you, Mr. Chairman. I am pleased to be here today to provide an historical overview of the Medicaid program, and talk about its role in financing health and long-term care services for low-income Americans.

I will summarize my statement, and have the full statement entered for the record.

In its 30-year history, Medicaid has been on the front lines in meeting the health and long-term care needs of our Nation's most vulnerable populations. It has enabled millions of Americans to access health care services.

Medicaid's role as an insurer and safety net is visible throughout our health care system. It finances care for one in four of our Nation's children, pays for one-third of the births in the United States, assists 60 percent of people living in poverty, pays for half of all nursing home care, and accounts for 13 percent of U.S. health care spending.

Medicaid influences and affects every aspect of our health care system. But Medicaid itself is really multiple programs, operated and configured somewhat differently, in each of our 50 States and the District of Columbia.

It is a health insurance program for millions of low-income children and their parents. It is a Medigap policy for low-income elderly and disabled Medicare beneficiaries, who rely on it to help pay their premiums and cost-sharing under Medicare. And it is a long-term care program that helps finance nursing home services for 1½ million elderly and disabled Americans.

Medicaid is not a uniform national program, but instead reflects different decisions by the States, in terms of who is covered, what benefits are offered, how services are delivered, and how much is spent for care.

From the perspective of who is covered, Medicaid is predominately a program for low-income families. But from the perspective of how Medicaid dollars are spent, Medicaid is largely a program for the elderly and the disabled.

Low income families, children and their parents, account for 75 percent of Medicaid beneficiaries, but only 27 percent of Medicaid expenditures.

Medicaid is an expensive program. No one would deny that. But it is expensive because the cost of caring for the nation's poor and most disabled population is expensive. Medical care in America is not cheap, especially when that care is for someone with chronic illness, mental retardation or Alzheimer's disease.

It is not the cost of caring for pregnant women and children that makes Medicaid a costly program. It is the cost incurred in Medicaid's role as a source of long-term care financing, and as a source of assistance and a safety net for those with catastrophic illness.

Historical rates of growth for Medicaid have traditionally been below those of the private health care sector. States have long had incentives to hold their costs down because they must match the dollars provided by the Federal Government.

But, as Dr. O'Neill says, in the early 1990's—most notably 1990 through 1992—Medicaid costs soared, largely motivated by increases in State use of provider taxes and donations, and disproportionate share hospital payments to generate additional Federal matching dollars.

These loopholes, I am pleased to say, appear to have been closed, or at least significantly restrained, by the action taken by the Congress in 1991 and 1993. Medicaid has now returned to its historical annual growth rates of about 10 percent.

Although today's debate about the future of Medicaid appears to be centered mostly on the dollars to be saved in the Federal budget, and the flexibility the States desire to have over how those Federal dollars are used, I think it is important to remember that Medicaid is about more than dollars and flexibility. It is about people, Americans who are poor and without the resources to pay for their own care.

Poor children—half of those on Medicaid are children—will never get ahead unless we give them a healthy start in life. And low-income elderly and disabled Americans cannot afford the financial burden that illness and the need for chronic care brings. It is about what happens to the one in eight Americans who rely on Medicaid as their medical safety net.

So, as you consider the options for restructuring this program, and reducing the level of Federal dollars committed to it, please bear in mind that these Federal savings projected in the budget resolution, of over $180 billion over the next 7 years, will significantly affect the resources available to care for the poor and the disabled in this country.

States have operated relatively lean programs, with relatively low administrative costs. And many may have to make deep cuts in their already low provider payment rates, or reduce benefits, or cut eligibility to sustain the program in future years.

Moreover, there are no magic bullets out there. If there were, States would have used them years ago to manage their costs. Even managed care offers only a limited potential for controlling costs from capitation. Because, today, it is mostly applied to low-income families who, while they are the major source of beneficiaries for the program, only account for about 23 percent of acute care costs.

If you save 10 to 15 percent over fee-for-service on care of that population, the net savings to the overall Medicaid program are only in the range of 1 to 2 percent.

Until we find ways to provide care more effectively and efficiently to the elderly and the disabled, and learn how to enroll that population, with their high chronic care needs, into more managed care plans, we will not be able to achieve the dramatic savings many anticipate from managed care.

Finally, I should note that the changes that may be underway on the Medicare side of the budget ledger could also significantly influence the Medicaid program because Medicaid has been the safety net for the elderly. Whenever Medicare premiums have been increased or cost-sharing levels were raised for the Medicare population, Medicaid has been used as the safety net to fill in those gaps for the lowest income people on the Medicare program.

Moreover, the pressure on Medicaid for coverage of the uninsured is likely to grow, not disappear, over the coming years as changes in the private marketplace make some of the current levels of uncompensated care funding in the system disappear. Without those cross subsidies, there will be even greater pressure on programs like Medicaid to help finance the cost of the indigent uninsured.

In closing, I would say that the path you follow must take great care to preserve and protect the safety net that this country has built for the lowest income and most vulnerable Americans. And I would remind you that, despite its many problems, Medicaid has in fact been a success in many ways as the health insurer and long-term care provider for the poor and disabled.

The costs we see today reflect Medicaid as a victim of its own success. In implementing solutions to meet today's budget crises, it is important not to undo the progress Medicaid has made in providing health care for tens of millions of low-income, elderly and disabled Americans.

Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Dr. Rowland appears in the appendix.]

And we will conclude this morning with Gail Wilensky, who was for 4 years the director of the Health Care Financing Administration. She is currently the chair of the Medicare Physician Payment Review Commission, and I swear that she has been before this Committee at least 15 times.

Gail?

STATEMENT OF HON. GAIL R. WILENSKY, PH.D., SENIOR FELLOW, PROJECT HOPE, BETHESDA, MD

Dr. WILENSKY. Thank you, Mr. Chairman, and Members of the Committee, for inviting me to appear this morning.

Medicaid has played a vital role in helping States finance the health care of our Nation's most vulnerable citizens. It is a flexible, State-administered program that relies on Federal matching grants, as well as State contributions, for its financing.

There is a lot of flexibility that is offered, in terms of services that can be provided, populations covered, and the way the program is financed.

I would agree with comments earlier in terms of the fact that Medicaid has met its basic objective of providing health care to selected categories of low-income populations. And I believe we ought to applaud those successes.

But we should also acknowledge the need for some changes, changes that would reduce the growth in spending and lessen the burdens that have been imposed on the States for administering the program.

There have been a variety of reasons given to explain the growth. Dr. O'Neill went through them; I will just highlight them very quickly. They include caseloads, additional requirements placed on the States by the Federal Government in the form of mandates, and the discovery of what were effectively Federal-only dollars during the early 1990's.

Let me just remind you of some of the increased use of mandates that occurred in the last decade. Those included the requirement that new populations be covered, such as pregnant women and children up to the age of 6, for people who had a family income of less than 133 percent of the poverty line, all children born after 1983 who were in families of poverty, expansions in the qualified Medicare beneficiary program, the QMB program, that Dr. Rowland just alluded to.

Also, new services were required, particularly through the EPSDT program, which required States, if services were found to be needed during one of the screening programs, to cover those services even if they normally did not cover those services in the Medicaid program. That had very major—I believe unintended—consequences in terms of the cost implications for many of the States.

New options were also made available. The most important implication in terms of spending is that it allowed the States to sometimes shift what had been State-only dollars to the Federal Government because of the new options that were made available.

Finally, a third factor has to do with the creative financing strategies that States use to fund their programs. As you probably recall, I was involved in trying to find a change to that. And it was so important to do that because what the creative financing schemes did was to undermine the basic premise used for the financial structure of Medicaid. That is that funding be shared through a Federal match of State monies.

In fact, the only real cost containment mechanism in Medicaid has been the fact that States have to put up some of their own money.

While it is true that some of the legislation that was passed in 1991, and also in 1993, did shut down some of the worst of the abuses with regard to disproportionate share spending and donation and provider taxes, I do not think that we have the problem completely solved.

Tennessee found, through a new taxing scheme, a way that probably beat its requirement. But, since TennCare has come along, and they are on a completely capitated system, that is no longer as much of an issue.

But there is an issue that is of great concern to me, and that is the fact of intergovernmental transfers. This was a concern to those of us in HCFA in 1991. But, to be very honest, we could not come up with a way then to devise a rule that would distinguish between an intergovernmental transfer that represented a legitimate transfer between levels of government and the movement of funds which resulted in only new Federal money coming into the program.

It is particularly problematic when the county or the State is paying itself because it owns the hospital, and is putting up its share of the match with an intergovernmental transfer.

The absence of the ability to distinguish appropriate uses and abuses of intergovernmental transfers is a good reminder that money is fungible, and that reliance on the use of State matching as a cost containment strategy is a genie that can never get put back into the bottle, at least as far as I am concerned.

Let me talk a minute about the waiver process. Although the amount of legislation and regulation associated with the Medicaid program is substantial, the flexibility provided by the waiver process is almost unlimited. Thus, provisions of Statewideness, duration and scope, freedom of choice, the Boren amendment, and so forth, have all been weighed as part of requests by States for more flexibility in designing their Medicaid programs.

This has allowed States to experiment with changes that have enabled them to improve the efficiency with which they provide care, and have effectively given the States more ability to provide care to some difficult groups.

The 1115 waiver process, which removes certain restrictions on the use of managed care, and also allows the coverage of individuals not normally covered by Medicaid, has been particularly popular. Since 1993, HCFA has granted 10 Statewide 1115 demonstration waivers, and 13 others are now under consideration.

While I think there is a lot of good that has been associated with the waivers, there are at least two areas of concern. One has to do with the administrative complexity, burden and costs associated with the application process, and subsequent monitoring by HCFA.

Despite the efforts that I undertook when I was at HCFA, and the ones I know Bruce Vladeck has undertaken since, the requirements are costly and burdensome. And State representatives—and you probably heard this yesterday—are only too eager to show the piles of paper required for waivers, or as part of the plan amendment process. And States continue to be frustrated at the time and expense required to include changes that have been tried in other States, or tried as a regular feature of the market.

I suspect, Mr. Chairman from Oregon, I do not need to elaborate on some of the frustrations that you felt going through this waiver process.

The States and the Secretary of Health and Human Services are forced to use HCFA's research and demonstration authority to continue implementing successful changes in the State program, because that is the only statutory authority they have available.

And Arizona's AHCCS program is a good example. By most all accounts that I am aware of, it has been regarded as a real success, both in getting people access to physicians and nurses through the use of managed care, and primary case management in the rural areas. By the way, they have also used managed care in long-term care and the disabled population.

Despite the fact that they have had these successes, have had growth rates in spending lower than other States, it still has to operate under a waiver because that is the only way it can continue operating without conforming to many of the requirements of Medicaid.

There is also a concern about the budget neutrality concept that has been used in determining the waiver request, when I believe any common sense would suggest that they have frequently been "costers" to the Federal Government.

It has to do with what the Federal Government would have spent, in the absence of the waiver. And let me use Hawaii as an example. What Hawaii was able to do when it came to claim Federal dollars was to use what are called "hypotheticals." That is what would have been spent if Hawaii had taken advantage of all the optional coverage and service that it could have, but did not. And they used those claims in order to try to claim new Federal dollars. That, to me, does not meet most people's common sense notion of what budget neutral is all about.

I think there were also some questions raised with regard to TennCare, which in the end was claimed to be able to cover 364,000 people who had previously been uninsured, as part of their budget neutral program.

Now I am a great advocate of the potential for managed care to provide care more effectively and efficiently. But, even for those of us who are ardent supporters, this seems to be a claim of savings that go beyond belief.

Now I am not necessarily against these expansions, but I am against the use of Federal money without having some payment on the other side. To my mind, it raises the point that tinkering with the existing program is not going to solve the fundamental problems of an unsustainable growth rate and costs of requirements, and that the major alternatives are the use of a cap payment per person or the use of a block grant.

Although these are good distinctions to make, on the basis of philosophy, some people are concerned that only a block grant will allow the Federal Government to make sure that it is not gained by the States, and also that it will reduce the uncertainty that even cap payments can have.

But I think there is really an issue with regard to the relief of the regulatory burden. The prescriptive nature of Medicaid, with regard to existing law and regulation, would then be replaced with a rather limited monitoring function by the Federal Government. It would have the Federal Government focusing on the outcomes, rather than on the process, and on prudent spending of money.

The result is that, if block grants were to be adopted, or cap payments per capita, States would be relieved of the burdensome reporting and filing requirements, but would be expected to provide some information on outcomes and performance, and to make sure that they were spending their money where they said.

Let me close with one last point. There is a significant philosophical issue that underlies this choice which really is not being stated very often. And that is whether the States, given additional financial resources, and with the Federal Government assuming a reasonable monitoring role, can be relied on to take care of their most vulnerable populations, or whether only the Federal Government can be presumed to care about these vulnerable populations, and without its active involvement at a micro-level, these vulnerable populations will not receive adequate or appropriate care. This is an issue that is worth debating.

Thank you.

[The prepared statement of Dr. Wilensky appears in the appendix.]

The CHAIRMAN. You state it very well. We had that debate with the Governors yesterday about why do you think we care less than you do about children and pregnant women.

Dr. WILENSKY. Exactly.

The CHAIRMAN. And the same voters that elect us elect you.

Dr. WILENSKY. Exactly.

The CHAIRMAN. And that was my experience 30 years ago in the legislature, even in what were modest budgets by today's standards, welfare—as we called it—was a major issue, and we debated it. Was there concern? Yes, there was.

Dr. O'Neill, let me ask you this. The budget resolution today will ask us to save $182 billion in Medicaid over 7 years. Give me your best judgment as to how you think we ought to do it.

Dr. O'NEILL. I cannot really recommend a course of action. That is not the role of the CBO director. But I can tell you that, as I indicated, I think one way to look at it is that the baseline is not a statement about what ought to be, or what is the ideal situation. It is a statement of what we believe will actually happen under current policy.

And under current policy there has certainly been an incentive for States to spend because each State's dollar is matched by from one to three Federal dollars. So there is an incentive in Medicaid to spend, and not to be thrifty. And, as everyone has mentioned, there have been many reasons for increases in eligibility, expansion of the program generally, and improvements in services. And thrift has not been that much of a factor.

So the baseline is just a statement about what we believe is going to happen, based on historical analysis. For example, the goal of the 4.8 percent assumption in the budget, according to the conference agreement is, as I said, sufficient to retain current levels of services and participation, but not expansion, not increasing participation as would be likely to occur under current policy.

Now, how to do it: I think one way is a block grant and the appeal of a block grant is that if the Federal Government says this is what we are going to spend, and allocates the pot among the States, one can be sure to reach the goal.

I am sure that many people will criticize it for other reasons but, in terms of an ability to actually control expenditures, a block grant does that.

The CHAIRMAN. Now let me ask you something. In your position as Budget Director, and everybody handles it differently. Is it your intention to pretty much give us the cold, stony facts, and not go beyond that, and give us no advice or suggestions? If we do A, we will get B. If we do X, we will get Y.

Dr. O'NEILL. Well, no. We have always provided options.

The CHAIRMAN. And so what I would like from you, are your suggested options which, in your judgment, would best get us to $182 billion in the most decent way.

Dr. O'NEILL. I believe that I did indicate several options in my testimony.

The CHAIRMAN. Give us your judgment on the options.

Dr. O'NEILL. I cannot tell you, because the calculation really includes a lot of political factors that are outside my bailiwick. Changing Medicaid, after all, really has to be done by some kind of consensus within the Congress, as well as among the Governors. It is everybody. And there are many different kinds of considerations that will have to go into what happens; judgments about what is the appropriate level of care.

That sort of question is something that I am really not equipped to answer. I might have a personal judgment about it, but CBO really cannot make a judgment about who should be covered by the Medicaid program, how far it should go. Should it move farther and farther up the income ladder, as it has tended to do, to go beyond the original population?

Those are issues that obviously affect costs, but they are the kinds of questions that I believe are not really appropriate for me to answer.

But CBO would be perfectly happy to provide options if you tell us what level you have in mind, what level of cost saving we can give you. There are many options.

The CHAIRMAN. The level we have in mind is $182 billion.

Dr. O'NEILL. And the block grant is obviously one. Within the current structure, caps could be placed on Federal payments of some sort. Federal matching can be reduced. These are the kinds of options that can be pursued.

Given that it is States that are involved—and States are really the engine for spending—some of the traditional kinds of cost-saving measures that have been used for Medicare would probably not be successful, such as trying to squeeze reimbursement rates.

The CHAIRMAN. Let me ask Dr. Rowland. Dr. Rowland, you are not so circumscribed as Dr. O'Neill. If we have to get to $182 billion, what do you suggest is the best, most decent, expeditious—call it what you want—way to get there?

Dr. ROWLAND. I think getting there will be very difficult, but you need to consider preserving the safety net piece of Medicaid. As Dr. Wilensky mentioned, you can go either with a block grant or with per capita spending limits.

In my mind, the per capita spending limits provide the ability to maintain some eligibility coverage for the population and preserve the safety net.

The CHAIRMAN. Well, let me ask you this. Yesterday, Governor Dean, who is also a doctor, mentioned this. When you say per capita spending, $100 per person, how does that limit the total spending if, instead of 20 eligibles, you have 30 eligibles?

Dr. ROWLAND. That is why it is not as fixed a control on spending. It allows for population growth in growth States, and it allows for changes in the eligibility levels of the population.

So it provides a larger safety net, but not at that same guarantee of savings.

The CHAIRMAN. But it does not get us to the guarantee of $182 billion either.

Dr. ROWLAND. Unless you severely limit the number of eligibles. You could put enrollment limits on the States as well, in combination with the per capita limits.

The CHAIRMAN. Dr. Wilensky?

Dr. WILENSKY. I think you have actually just heard the real dilemma you have. I think $182 billion is a large amount to be saved. I am more confident in how you are going to get to your Medicare savings. But I think it is possible.

And I believe the only certainty is through a block grant. That limits the Federal risk. Frankly, it is going to require a lot of creativity and innovation on the part of the States. I think that, in return, giving them the maximum amount of flexibility on their side is the only fair thing, and probably the only political thing you can do, in the sense of trying to get any of their support.

I would like to mention that there is at least some limited indication that there are substantial savings potentials from long-term care. I agree with Dr. Rowland. We do not have nearly the information, and that is a very important issue.

Fortunately, because Arizona has had a full waiver for its program for several years, including the long-term care and disability population, we can see that they have had abilities to achieve 18 to 20 percent savings, at least by some calculations.

It means that we had better make sure that HCFA is able to provide a best practices information role for the States, so that States do not have to learn entirely on their own each time.

But I think what you will be pressed to do is to use a block grant because of the size of the savings. Cap payments per person allow one opening. It makes it harder to have the certainty with respect to your budget.

Frankly, when you are looking for this kind of savings, because it presumes an entitlement, it may make it more difficult because the States need to be able to look at their populations and have some flexibility as to whether they will have a clinic available, and not have the entitlement of services to an individual that has come through the past program. Although, other things equal, I am a low-income voucher proponent myself.

The CHAIRMAN. Senator Graham?

Senator GRAHAM. Thank you very much, Mr. Chairman.

I would like to continue to pursue the question that you had. Clearly, the Federal Government can achieve the $182 billion cuts. We just said that we aggregate the amount of appropriations over the next 7 years, and assure that it comes in at $182 billion less than the trendline upon which current projections are based.

The difficulty is, how do you make changes at the level where you are delivering services in a way that does not adversely affect the population you are attempting to serve.

It seems to me that the formula at that level has the following essential elements: One, what you are currently spending in the categories of elderly, disabled and other Medicaid beneficiaries; two, what your projected increases in those cost factors are; and three, what is the potential change in the population that you are serving? Are those not the essential three variables that we are dealing with here?

If your goal is not to restrict service, if you want to continue to provide service to the same population that you have done in the past, then you are focused on factors one and two. What can you do to reduce current levels of cost, and what can you do to restrain the projected inflationary pressure?

If you were advising a Governor who now has this program, either under a block grant approach or a per capita restrained program, what would you recommend to a Governor who wanted to continue to serve the current eligible population and others who might enter that eligible population, with a minimal degradation in the quality of care?

Dr. WILENSKY. I think that there has been a substantial amount learned, particularly in some of the high-cost areas. The first thing is, if they are not in managed care with regard to their acute care population, they ought to start moving quickly. There is a lot of indication that there are savings potentials of at least a high single digit. Probably, for some of the States who have not done very much at all in this area, it may be in the double digits as well.

The second thing is to look at ways to keep people out of high-cost institutions. Particularly with regard to nursing homes, places like Oregon and Washington have had some successful programs that have lessened the need for institutional care. They ought to go and learn, and talk with them.

Also, looking at putting your disabled and your long-term care populations into capitated arrangements, spending time with Arizona, which has done the largest attempt to use alternative delivery structures.

And then to make use of this new flexibility, and to think about the appropriate use of services in schools for some of the low-income populations, or in clinics for high-risk populations that have been possible but difficult to do with some of the restraints that have been in place.

And again, States could do almost anything if they had the strength, the patience and the time to go through the waiver process. There are an awful lot of ways that I think can be used to provide services in the short term.

For States that have been very aggressive in claiming Federal dollars in the past 4 or 5 years, they will have a much easier time, because they have a lot bigger baseline to start from. For States that did not, they will have a little harder time.

I think the issue of how you distribute the future growth, in terms of weighing long-term care populations, disabled, against the moms and kids, is a very serious issue that Congress is going to have to wrestle with.

When you were giving money on a per-person basis, which basically was in the program, you did not need to worry that some people coming in are much more expensive than others—the long-term care and the disabled.

Now, when you go and do the block grant, you are going to have to think about not only how to use presumptions of future enrollment, but to make some weighting because these populations have costs in the neighborhood of $7,500 or $8,000 for long-term care and disabled versus $1,000 to $1,600 for the kids and moms.

So you are going to have to think hard how to distribute that future money, and you are probably not going to want to use the same formula you used in the past.

STATEMENT OF DIANE ROWLAND, SC.D., EXECUTIVE DIRECTOR, KAISER COMMISSION ON THE FUTURE OF MEDICAID, WASHINGTON, DC

Dr. ROWLAND. A lot of these reforms take time. And the States like Oregon, that have a long history with managed care, and with community-based care for the elderly, are way ahead of the game in terms of trying to implement these reforms.

The States I would worry about are those who are the least experienced with a lot of these new changes, that are going to need some flexibility and time to develop their systems. Because what we see is that when States move too quickly, without the infrastructure there, problems often occur, as we have seen in some of the States that have moved very rapidly into managed care.

But I think the other point that is very important is that the States are so very different today in the way in which their Medicaid programs are structured. As Gail mentioned, you are going to have very difficult problems if you are in a State where a lot of your dollars are committed to long-term care because you may not be able to move those dollars as quickly. About 20 States really have very heavy long-term care investments, as opposed to acute care.

We need to begin to look at how we finance long-term care services in this country, and what the appropriate role is for Medicaid versus other sources of long-term care financing.

Second, we need to look very carefully at the interaction between the Medicare program and the Medicaid program because I know one of the areas that many of the Governors would like the Federal Government to assume more responsibility for is that dual-eligible Medicare and Medicaid population, where they feel they have no control over what happens to Medicare, yet they bear the cost of those changes.

The CHAIRMAN. Dr. O'Neill?

Dr. O'NEILL. Senator, I think that it is hard to envision exactly what will happen under a block grant, or to really prescribe what States ought to do. But I do believe that, given much greater financial responsibility, or actually full financial responsibility, States will become even more innovative than they have been in the past few years.

Although managed care, you know, is an obvious solution that many States are pursuing, and probably will continue to, there are many decisions that can be made about different kinds of modes of delivery that we may not know about now, that States will have a strong incentive to pursue if they have financial responsibility.

Now it is true that tradeoffs will have to be made. States faced with fixed amounts from the Federal Government, rather than the current matching system, will have to consider whether the current eligibility conditions are what they want to continue. So, if they want to continue to have improvements in the quality of services, even with greater efficiency, they may have to make tradeoffs and either impose fees on the non-poor groups that have recently been covered or remove eligibility.

You may be interested in what we have found, that looking at what the actual results of some of the recent expansions have been, there have in fact been offsets with private insurance for many of the children. This seems to be particularly true of the non-poor children who have been covered under Medicaid, where parents reduced their private coverage by their employers because of the increased Medicaid eligibility.

As a result, there was no net increase in coverage of these children. It remained just the same. It was merely an offset, a substitution of the Federal Medicaid for the private.

Now the studies seem to suggest that that is true. But, nonetheless, given that kind of situation, States might in fact choose to reduce—or certainly not expand further—eligibility of the non-poor populations.

Senator GRAHAM. Mr. Chairman, if I could just make a summary statement.

There was one comment made about the relationship of Medicaid and Medicare. I believe this is the only Committee in the Congress that has jurisdiction over both of those programs, which I think places some particular responsibility on us to be sensitive to that relationship.

I would hope that, as we go through this process, that would be a particular area of attention because I am very concerned that, if we do not do that, and we continue the requirement on the States to pick up things like the Part B premium or the indigent elderly, many of the other out-of-pocket costs of the indigent elderly, that will become a very distorting influence on how States can allocate their funds they receive, whether they get them from a block grant or a per capita grant.

So I am pleased that issue has been raised. I think it is an especially important one for this Committee.

The CHAIRMAN. Senator D'Amato?

Senator D'AMATO. Thank you, Mr. Chairman.

Dr. Wilensky, I think you do an excellent job in summing up the basic question that we face. In the conclusion of your testimony, you state, "With reference to the block grant versus entitlement debate, the issue is whether States, given some additional financial resources, and with the Federal Government assuming a reasonable monitoring role, can be relied on to take care of their most vulnerable populations, or whether only the Federal Government can be presumed to care about these vulnerable populations, that without its active involvement, those populations will not receive adequate or appropriate care."

How would you answer that question? And why would you answer it the way you do? That goes right to the heart of the issue.

Dr. WILENSKY. I think that there may, on occasion, be one or two exceptions. But, in general, I believe that States, because they face their citizens more immediately and more directly, can indeed be relied on to care about their vulnerable populations.

I think the Federal Government as a financer has a prudent role to be sure that its money is being spent for low-income populations, on health. And I would hope it would begin to have a limited number of measures that are made available in terms of what is actually done with these dollars.

The irony of all of the burdensome requirements is that HCFA has basically no information about the health status of the people on Medicaid. There are no uniform reporting requirements. There is no uniform data. There is very little in the way of outcomes information. So they have a ton of requirements, and basically no information on what has happened.

I think a very small number of information items could be requested, and also that the States make what they are doing public to their own citizens.

But the short answer is I believe you can rely on the States. One or two, perhaps not. They will probably escape all the requirements HFCA puts in place, no matter what.

Senator D'AMATO. Dr. O'Neill?

Dr. O'NEILL. I agree. We actually know very little about the outcomes on a State-by-State basis. We know how much each State spends per capita, but there is not necessarily a relationship between the quality of care offered and the expenditures per capita.

Senator D'AMATO. Dr. Rowland?

Dr. ROWLAND. We do know that there has been notable progress over Medicaid's history though, in improving access to care for the poor. The poor with Medicaid do better than the poor who are uninsured. So I think we ought to be very careful not to undermine the success of this program. And it has been a Federal/State partnership.

I do, however, think that the States have always been free to do whatever they want to do with their own State dollars. What we are talking about here is how Federal dollars should be used by the States, in combination with State dollars.

And I think it is very important that whatever Federal dollars are in this program are equally matched by State dollars, so that we do not just see a shift of responsibility in terms of losing State dollars and only having the Federal dollars in the program. Some fear that could be a consequence of the block grants, that they will result in a cutback, not an expansion of State effort.

Senator D'AMATO. Dr. Wilensky?

Dr. WILENSKY. Well, I think that is really up to you with regard to what it takes to get the Federal block of money. It can certainly be a requirement that if the Federal Government is going to put up $2 million, that the State has to put up $500,000 to keep it in proportion, or whatever amount.

Now whether those are real State dollars? As I think I indicated, we had an experience that shows you cannot always tell what is real money in the States. And money is fungible, particularly with regard to intergovernmental transfers. There is a real question as to whether this is really new money that its coming in.

But I think the issue of maintenance of effort can be done with the requirement that, in order to get the block grant, or whatever it is, States have to show that they are spending a certain block. And, if they do not, they do not get their full allotment. But, unlike the current system, just because they spend more, they do not get more Federal money.

That is really the issue. As the Federal Government absolutely limits its liability, the only way the Federal Government absolutely limits its liability is a block grant. Period.

Senator D'AMATO. Well, we still get down to the issue, do we not, as to what requirements, in terms of maintenance of effort, you would make. And then you have the counter-argument of, give us the ability to make these decisions, and do not tie us down to these maintenance of effort agreements.

I think that most of the Governors are saying, if you are going to give us block grants, give us that block grant, and give us the ability to determine how we fund what programs, and how we utilize those dollars.

And here comes the question. If somebody saves, should they not be able to use those dollars wherever else they want?

Dr. WILENSKY. Well, I think it depends on whether you, as a Federal Government, as a Congress, are concerned about spending levels on other things than health care. You start to cross categories very quickly.

Senator D'AMATO. If I am averaging $10 under the present program, and by innovation, et cetera, I am able to do the same program, same quality, for $8, should the State not be able to take those $2 and just cut spending, or put it into another program, or reduce taxes?

Anybody?

Dr. ROWLAND. It depends on what accountability you want over the expenditure of Federal dollars. If you want to say that the Federal dollars in the Medicaid program are to be used exclusively for the health and long-term care needs of low-income Americans, then the State would not have that flexibility.

If you want to treat it more like revenue sharing to the States, then certainly there could be full flexibility.

Senator D'AMATO. The question is, have the States arrived at a point? I think they have arrived at a point. See, our mentality is that the Federal Government knows best. What the Governors are saying is, look, we will take the program, but give us the ability, if we can reduce our costs, to then do what we want with the savings. There is an assumption that we are going to carry out our responsibilities. There are a variety of things we can do with those dollars. We can reduce the cost of government to people. That is what we might choose to do.

If I am a Governor, why should you tell me that I have to spend those dollars, those additional dollars I have saved now, by more cost-effective means, in whatever way you say I must, even if it is something that is worthy?

You are saying that, no matter what level of efficiency I achieve, even if I can more effectively administer the program, save 20 or 30 percent, I cannot then give those savings to the taxpayers. Is there not something kind of amiss there?

Dr. O'NEILL. I think there are two different issues. One is accountability for the Federal component. There is obviously a national interest in Federal funds. And the Federal Government has every right to require that the Federal funds be spent on particular populations.

But what the States choose to do beyond that is really a matter of State interest. And I think here, I tend to believe that States care as much about their citizens as everybody else in the country cares about their residents, and would do the best they can.

Once you have a maintenance-of-effort requirement that State dollars have to go back, in effect, to the old matching formulas, then you do take away some of the incentives for efficiency that you hoped to get out of a block grant arrangement.

Senator D'AMATO. Thank you very much, Mr. Chairman.

The CHAIRMAN. Senator Grassley?

Senator GRASSLEY. I will start with a question for you, Dr. Rowland. And my question is predicated on the proposition that we could have a block grant. As you know, Medicaid programs currently require that services be provided for the elderly on the one hand, the disabled on the other, and then family, children and pregnant women.

If we were to create a block grant which eliminates an individual Federal entitlement for these categories of people, should there be a federally-required set aside of program monies for one or all of these categories of people, but defined more generally than is now the case, when it is more categorical, you might say? Some have recently advocated that, at the very least, we should retain a required focus on children in low-income families, as an example.

Dr. ROWLAND. Well, clearly, the current list of categories and rules about who is eligible, and who is not eligible for the program has a long history, and does not make much sense. It is really a patchwork of eligibility, and it would be preferable to establish eligibility more directly related to income and need than to some of the other categories that have developed over time.

I think the problem, in terms of a block grant, is that if you try to establish different set-asides within the block grant, you quickly start adding the strings that the Governors say they do not want.

You also have very different allocations across populations today, State-by-State. It would be fixing one State to remain locked-in as a long-term care State, and another State to potentially forever remain a low-income-family oriented State, if you froze in the existing patterns.

If you created a new set-aside, you might well have many States that have invested heavily in long-term care that have to reduce dramatically the amount they can spend on long-term care in order to accommodate whatever the set aside is.

While in theory it offers good protections, the reality of how Medicaid funds are disbursed today means that the formula fight becomes even greater than it already is with the block grant.

However, I think there is a policy imperative to see that some of the very children in this country who are uninsured and below poverty potentially do have protection. But that really does get into a decision about what the priorities are for the use of Federal funds.

Senator GRASSLEY. I presume you are saying that if we are going to block grant, block grant, and do not try to compromise it?

Dr. ROWLAND. Well, I would prefer that you not block grant.

Senator GRASSLEY. Yes.

Dr. ROWLAND. But, if you block grant, I think that you immediately get into distributional issues that will make it very difficult. It would be my preference to see children protected in a block grant, but I think administratively that will be very difficult to implement.

Senator GRASSLEY. All right.

Another question, Dr. Rowland, but also for you, Dr. Wilensky. This has been asked already, so my point is to try to clarify it to a greater extent, and more specifically.

The point has been made that managed care probably will not save much money in Medicaid, as some advocates might think it would. Of course, this is partly because it has not been used in the long-term care area for the elderly. Nor has it been used for chronically disabled.

Since a major portion of Medicaid money goes for these groups, it does not look as though managed care will help very much with that portion of Medicaid spending.

Two questions—one is whether managed care has any potential as a methodology for providing services for the long-term care needs of these groups? And maybe a better question is whether there are not other appropriate methods of providing high-quality services to these groups while saving money?

I am referring to case management for long-term care, and to home and community-based waivers for these population groups. For instance, my own State of Iowa seems to have had some success in holding down expenses for these groups through case management coordinated through the area agency on aging, and through home and community-based waivers.

If you could address those two points, I would appreciate it.

Dr. ROWLAND. Well, clearly, until one begins to move to better coordinate and integrate the services for the chronically ill and the disabled, it is going to be very difficult to achieve great savings in the Medicaid program because that is where the biggest costs are.

There have been some very positive experiences with case management of some of the chronically ill and disabled populations, but there has not been a great deal of use of managed care in capitated payment arrangements for this population.

Oregon is just beginning to move this population into a capitated, managed care plan. I think Arizona has some experience, but it has been a rather unique program from its beginning. We need to look at how to better provide those services.

But it is not even people in the community who incur the large costs for Medicaid. Many of the people are those in institutions where the cost, for example, for a child in an institution for the mentally retarded can exceed $50,000 or $55,000 a year.

So until you begin to also get some ability to find alternatives to institutionalization, which we have not really found, it is going to be very difficult to handle the most expensive patients on the Medicaid program because they are in institutions. We have usually ended up finding that home care adds new beneficiaries to the program, but does not necessarily replace those who rely on institutional care.

Senator GRASSLEY. Dr. Wilensky?

Dr. WILENSKY. The concern about how well do we know how to reduce spending for the elderly and disabled population on Medicaid is fair enough. We have less experience in managed care.

As I mentioned earlier, Arizona has some very promising results, not just because they use managed care. They use adult day care; they use small group homes of three individuals in homes. They use a lot of innovations. And this coverage has been going on now I believe about 4 years, the long-term care part of the Arizona program.

Statistics that I have seen indicate not quite 20 percent savings for the elderly, somewhat over 20 percent savings for the disabled population. Again, those are the areas we have had the least efforts attached to, so we ought not to be surprised that the greatest potential for saving is there.

Let us be clear. We have talked a lot about managed care. I think it offers coordinating the care of people who use a lot of services. It makes a lot of sense. But nothing about block grants forces States to use managed care. In areas where taking care of frail elderly in a different environment makes the most sense, the State can do that.

What we are going to need the Federal Government to do is to get information moving. A lot of States have tried things. Some of them—Oregon and Washington for at least 10 or maybe 15 years now—have tried non-institutional alternatives to long-term care.

Many of the State Medicaid directors have been around a while, and know that there have been a lot of new Governors elected. Their Medicaid people may or may not know that. If we relieved it from some of the waiver monitoring and filing requirements, the Federal Government could make sure that this information is exchanged. It is an important role.

The CHAIRMAN. I might call this to Chuck's attention. You mentioned Oregon. Jackson County, Oregon got a waiver all by itself in about 1981 for home-based care. I did not know a county could get one. And then Oregon got it a year or two later. And we have just about been able to double the population served for the same amount of money.

Dr. WILENSKY. And there really have been places that have had very good success in these high-cost areas. We need to make sure that the rest of the States know.

Fortunately, your attempt to get savings has a step-down in spending, so you are not trying to take it from the current spending rates down to where you ultimately want to go.

Dr. Rowland raised a very good point. States that have never tried this are going to have a lot of learning to do quickly. But you are not trying to go from here to there next year. You do step it down, and you need to exchange information and let States do it in the ways that make the most sense.

Dr. O'NEILL. In terms of the overall cost savings that can be expected from managed care, we do know that one should discount what could be obtained even from the traditional populations that already have experience with managed care—the nonelderly, nondisabled children and adult population—which account for about one-third of the expenditures under Medicaid.

It is true that it is a smaller portion but, nonetheless, if you figure that managed care might reduce costs by 10 to 20 percent, or a third, that would mean a reduction in overall costs in Medicaid of 3 to 6 percent. It sounds like it is a small amount, but remember we are trying to get to 24 percent reduction, so you are getting some of the way, even with the traditional populations.

I think there is a presumption that, under a block grant system, States would be seeking cost-saving kinds of innovations, and that they would try to develop managed care for the other populations.

As Gail and Diane have pointed out, there is some potential there. We do not know how far it would go. Arizona sounds promising, but there may be other modes. Again, given the degree of need to have waivers for various kinds of changes, States may innovate in ways that we do not even know about now.

Dr. ROWLAND. The other thing, however, that is very important to bear in mind is that Medicaid has not traditionally been a very high payer for the services that it purchases. It does not pay physicians anywhere near as well as private insurance plans. So a lot of the savings that can be expected to be achieved in the private insurance market by converting to managed care, may not be realized in the Medicaid program.

The second piece is that one of the most important things in managed care is maintenance of the population in a plan over a long period of time, so that the use preventive services can reap long-term benefits.

The current Medicaid program, especially with its relationship to welfare, has very high eligibility turnover, which in many ways has compromised the ability of managed care plans to do some of the kind of coordination of services that provide the real savings.

Dr. WILENSKY. But you do not need to have that happen if you do not have that same requirement.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. Mr. Chairman, may I apologize to you but, most particularly, to our panel for arriving late. I was with Dr. Rivlin in the EOB, talking about yet other budget problems.

Senator ROCKEFELLER. You were on television last night.

Senator MOYNIHAN. I was on television last night? Good heavens. Well, no one told me. I may have had to watch.

One of the things that is a little mystifying to me is the enthusiasm for block grants, which is obviously doctrinal. It is obviously a Republican enthusiasm. And I think some of those Republican Governors are going to wonder what happened to them.

We had the Governor from Illinois in yesterday, very much in favor of block grants. I wonder if he really knows that in the disbursement of Federal funds, what you pay in as against what you get out, Illinois ranks 48.

And the disbursement is very much skewed against the Wisconsins and the Michigans. Michigan is 45, Minnesota is 46, Illinois is 48, Connecticut is 51, New Jersey is 50.

But in Medicaid we have a formula which is 50 years old—or will be next year—the Hill-Burton formula. And the Hill-Burton formula allocates the Federal sharing in terms of the square of the difference between the median income of the States and the national median income. I mean we wrote algebra into the Hill-Burton Hospital Construction Act in 1946.

Twenty years ago, I proposed a bill, instead of making it the square, why not make it the square root, to see if it might even out some of these things? But it did not get anywhere. Russell Long would not hear of it.

But are we now going to put in place with the block grant the result of 50 years of this formula, which was designed to move resources from one State to another, from one region to another very openly?

Dr. Wilensky? Anybody?

Dr. WILENSKY. You have not, to the best of my knowledge, because the Congress decided on how to distribute future money. And the fact is that many people have felt that the basic Medicaid formula now, which only realized on per capita income, has not been a very good one for a long time.

GAO has had reports advocating the use of other fiscal capacity and need measures. But trying to redistribute Federal money, without making a lot of other changes, is a very difficult activity, as I am sure I do not have to tell you, as members of Congress.

Right now, that is going to be forced as an issue. You are going to have to decide the future growth, how should it be distributed?

And especially in a block grant, where you do not have per capita spending, as we have had in Medicaid, you have to decide if you want to take account of projected enrollments in the future. Do you want to weight them by long-term care, disabled, which are very heavy users, as opposed to the moms and kids, who are very light users of services?

So this whole issue of how to distribute the future money is something you have to decide. And, actually, it is possible—although probably it will not happen—that Governor Edgar feels that he can do better than 48th on the next round, or at least he is not going to do very much worse.

Senator MOYNIHAN. He cannot do very much worse.

Dr. WILENSKY. He cannot do much worse, exactly. He cannot do very much worse.

But the question with the block grant is, if the Governors say, if you want us to accept a slower growth in spending, you need to give us maximum flexibility. Otherwise, we do not want to play. And that is really the tradeoff. Is it appropriate? Is it worthwhile to say to the Governors, here are the rules that you have to play by. You have to either show us or not show us where you are spending the money. Is it going for low-income populations and health, whether or not you have a maintenance of effort, and if you have any reporting requirements, in terms of what you actually have done with the money, performance measures? Otherwise, here is the money. Come back next year.

Senator MOYNIHAN. Well let us ask Dr. Rowland. What do you think about this? Do you not think we are freezing in a half century designed to redistribute resources?

Dr. ROWLAND. I think it freezes in place an existing set of State choices that have happened, at least within the Medicaid program, over the last 30 years, where different States have made very different choices about how to spend their Medicaid dollars, who to cover, and what services to cover.

Senator MOYNIHAN. And the ratio by which they are reimbursed.

Dr. ROWLAND. And the ratio by which they are reimbursed has been there as well.

So the dollars today are not equally distributed, based on poverty. I included in my testimony how the spending distributes per low-income person in each State, and it clearly has very little relationship across States.

In the future, one can also predict that if you lock these patterns into a block grant, with a fixed Federal allocation, the next time there is a recession or a major problem in some State with growth, due to a large immigrant population coming in or increases in poverty, all of a sudden we will be back looking at the formula again, and discussing how fair or unfair it is.

Senator MOYNIHAN. I would wish much luck to the people who find it unfair because, if it is unfair to them, it is more than fair to someone else. And we have a simple rule here—one State, two votes.

Dr. O'NEILL. The basic rankings among the States have remained roughly the same. But certainly some States have gone up and down in their share.

I think there is actually an opportunity right now to make the distribution more rational than the outside impartial observer might think.

I do not believe anyone has decided that they would be frozen. I think it would also be unfair suddenly to change the allocation from this year to next. You would not really want to put a State in a situation, in which it had been receiving one amount of Federal dollars, and the next year be told that it would be getting half that amount. That would really put an impossible burden on States.

So whatever is done in moving away from the current allocation, is a matter of happenstance. If you look at two States that have the same per capita income—the same proportion in poverty—one will be getting a larger share. Even in the same populations, one will be getting a larger share than the other because of decisions they have made.

Senator MOYNIHAN. Granted. But, I just want to say this, Mr. Chairman.

The choices made at State levels can be happenstance, but the allocation, the matching formula——

Dr. O'NEILL. The matching formula, yes.

Senator MOYNIHAN. The formula is deliberate social policy to distribute income from one portion of the country to the other. And it has been there for a long time.

Dr. O'NEILL. For example, in comparing California and New York, California has almost 15 percent of the poverty population, and receives nearly 10 percent of Federal Medicaid expenditures. New York has 7.5 percent of the poverty population, but it receives 12.5 percent of Medicaid dollars.

Senator MOYNIHAN. But those are choices. But they both get a 50 percent match.

Dr. O'NEILL. They both get a 50 percent match. They are both high per capita income States.

Senator MOYNIHAN. I have used up my time. I thank the Chairman.

The CHAIRMAN. I have not looked at your list, Pat. But could I guess, if Illinois and Connecticut are the worst off, that West Virginia might be one of the best off?

Senator MOYNIHAN. No, sir.

The CHAIRMAN. It is not?

Senator MOYNIHAN. You need Air Force bases. I will get the answer for you by the time I come around next. [Laughter.]

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. Thank you very much, Mr. Chairman.

I would like, if I could, to submit some questions for the three witnesses for the record——

The CHAIRMAN. Absolutely.

Senator ROCKEFELLER [continuing]. About Medicaid, and turn to Dr. Wilensky for a subject which is very appropriate to this Committee, but not immediately before us, with your permission.

The CHAIRMAN. I would only call your attention one thing. I remember, years ago, we were doing a unanimous consent on housing on the floor, in about 1979 when Senator Byrd was Leader.

And you know, from time to time, we agree that we will reserve an amendment for Senator Moynihan or Senator Packwood. We reserved one for Senator Helms, not knowing what it was. And it turned out to be capital punishment. So, with that admonition, yes, you may turn to another subject.

Senator ROCKEFELLER. This will not be that.

Dr. Wilensky, you are extremely busy. You are doing PPRC, Project Hope senior fellow. I think you run a 5-minute mile every day.

And you also have something which people do not know that much about even yet. But you are a neutral trustee in the Combined Benefit Fund, which has to do with retired coal miners and their health benefits. And you were also a part of the solution that was worked out for all of this in 1992.

I just want to ask two very short questions about that fund to which you belong. And the reason I am asking the questions is because there were some statements in the other body that I think need some clarifying.

Generally speaking——

The CHAIRMAN. I might add, what he is about to ask is a different form of capital punishment. [Laughter.]

Senator ROCKEFELLER. What is your assessment of the financial health of the fund, and the financial analysis of the health of the fund that was prepared by Ernst and Young, with a lot of it being done by your former colleague, Guy King?

Is it an accurate analysis of what you expect for the fund? And can you comment on that report, to the extent that you choose to?

Dr. WILENSKY. It has been a little while since I have read the report. But when the fund was concerned as to whether or not the long-term actuarial balance seemed to be about right for the fund, because there appeared to be an initial surplus of funds showing up in its accounts, I had encouraged the chair of the trustees to ask Guy King—who, because he was at Ernst and Young, as opposed to Ernst and Young per se—to look at the issue, or at least to be on a list that they might solicit bids from to look at the issue.

And the reason I made that suggestion is because I have the highest regard for Guy King, from my knowledge of him as a former HCFA actuary, and because of his knowledge about the Medicare population. So I had been strongly behind their turning to Guy King, as well as to several other actuarial firms, to do this assessment.

My recollection of the report is that there is substantial uncertainty regarding the need for future funds in the next 5 to 10 years. This is a very old, sick population. That is who the retirees and their dependents are under this fund.

While there appeared to be an early surplus of funds, going through a set of projections indicated that the fund should be regarded as being in actuarial balance. There was no certainty at all that there would be a future surplus, and that the fund's strategy should basically continue as it is in the future.

As I said, I have great confidence in Guy King's analysis, and I think the seven trustees, or at least the majority of trustees—I do not remember any dissenting voice—accepted that report as being a useful and meaningful report.

So I would accept his assessment that, while there is some initial surplus, there was substantial uncertainty, and it ought not to be reduced.

Senator ROCKEFELLER. Do you think the fund has been managed properly?

Dr. WILENSKY. I think there has been some feeling that more benefits could be provided under a different arrangement, and that the combined funds went through a long process of looking for a way to increase managed care and competition, per the directions of the Congress. And I think it had been reasonably managed before. I think it is showing a better use of the money now. And it has been proceeding in a prudent way.

So I am not aware of any mismanagement. And I think it has gone through a number of steps in the year and a half now that I have been formally associated, which I think are improving it.

Because of my involvement with resolving disputes at HCFA, and because of my involvement in settling this portion of the Energy Act, I had an opportunity to look at their management. I think problems that existed in the past have been dealt with, in terms of utilization, pricing, reimbursement to physicians that went beyond the Medicare fee schedule. There were some problems in the past that have been well dealt with.

So, yes, I think at this point it is well managed, and it is seeking ways to improve its management.

Senator ROCKEFELLER. And then finally, Dr. Wilensky, I think I read pretty clearly from what you are saying, that any sort of arbitrary reduction in the reserve—as a health care program, you have to have some reserve for exigencies—a broad-scale assault on the reserves in the fund might be something that you might question.

Dr. WILENSKY. I will be stronger. I think it would be a mistake. This was a very painfully wrought solution. I think that there are now adequate funds in the future to take care of the miners and the retirees. It has been put together in a way that did not raise issues with regard to employer mandates, or bringing in employers who had never had anything to do with the unionized mine workers.

There are always some tinkerings you could do, but it is in general a fair package that solves a difficult problem. I would think it would be a very big mistake to open it up to wholesale changes of any sort, especially funding.

Senator ROCKEFELLER. Dr. Wilensky, thank you very much. And, Mr. Chairman, thank you very much sir.

The CHAIRMAN. Senator Simpson?

Senator SIMPSON. Mr. Chairman, I thank you.

It is good to see people come to these hearings. I have had several in the last few days, and not a soul showed up. [Laughter.]

I looked around for my colleagues. They keep talking about Social Security, but nobody ever shows up. I said we are going to have an oversight hearing on Social Security, and whether it will be insolvent. And I notice that they are all over on the floor, talking about the insolvency and the robbery of it, but they never come over here.

I would suggest that any of my colleagues wishing to address the issue of Social Security and its insolvency drop by. Feel no fear.

The room is filled with people. Well, enough of that. Wretched rascals.

Now let me ask a question here. Because, as we deal with insolvency of systems—we talk of Medicare going broke in 7 years, Medicaid going up 10.5 percent, 11 percent—let me ask Dr. Rowland, would any modest cost-sharing requirements discourage Medicaid beneficiaries from seeking unnecessary services, thus obviously reducing the cost of the program? Or do you think that any copayment—any payment—would cause a beneficiary to forego needed services?

Dr. ROWLAND. I certainly think that the evidence on cost-sharing for the low-income population shows that they can bear very nominal levels of cost-sharing. Anything above that ends up resulting in reduced utilization. You certainly do not want to reduce utilization among this population for prenatal care and preventive services for children, which seem to be those services which are most likely to be reduced when cost-sharing is imposed.

Individuals at somewhat higher income levels, who are coming onto the Medicaid program through some of the expansion of coverage at higher income levels, are already being asked to pay some cost-sharing. And, in fact, you may want to continue to look at that as a potential way to accommodate coverage of the near-poor.

However, States have found in the past that imposing cost-sharing requirements, especially in the example of prescription drugs, can end up to costing more administratively than they collect or save in reduced utilization.

Senator SIMPSON. Well, as we get into the tough votes, it is tough enough to vote on the resolution. But when we get to doing real yes and no votes later this year, then we will see where all the courage really is. But, at some point in time, at least for me, certainly with Medicare, you have got to have some kind of minimum payment when you go to a doctor.

I think the First Lady was recommending that early in her remarks on health care reform. Ten bucks, $15 bucks, $20 bucks, $25 bucks, that is what we are talking about.

That is Medicare. But I am thinking, in Medicaid, surely the price of a theater ticket would not be an oppressive burden for someone. And it saves billions over years when you have a minimum kind of a payment.

You say what is appropriate—I forget your word—but I think there has to be something there to indicate that you are part of the system which is the most generous system on earth, and you ought to know it. Ten bucks, $5 bucks, $6.50? What do you think?

Dr. ROWLAND. Well, $10 for a family whose income can often be $400 a month, can be a substantial amount. The kind of care you may discourage with that may be immunizations for low-income children.

I think you have to be careful that what you impose in the way of cost-sharing does not delay primary and preventive care, and result in higher-cost inpatient care. Some of the experience in the past with cost-sharing has shown that it is in fact penny-wise and pound-foolish because we pay more when people come in later and sicker for care.

Senator SIMPSON. I am aware of that. But I am also aware of systems going broke. And when they go broke, then nobody gets too much care.

So that is something to consider. And the immunization program is in disarray, even by the proponents' discussion of it.

So I think we have to remember that it is easy to flee quickly to those terms, but the real issue is that, in all the things we are doing, and talking about compassion, how are we compassionate when we cannot control the program or the programs? I am going to vote on a $5 trillion debt limit, pretending that things can go on, and that the people you care the most about will be taken care of, when they will not. Period.

Dr. ROWLAND. Well, I think there are obviously very difficult choices ahead for how you look at the dollars that you want to save, in terms of Federal spending, and what the consequences are for some of the populations out there.

To the extent that people can be enrolled in capitated plans, with minimal or no cost-sharing and the plan controls utilization, you gain some of the effects over utilization without imposing barriers to access.

Senator SIMPSON. Well, these are the problems that confront this Committee. And it will be here where the heavy lifting is done. I can see that. I did not see that when I was not a Member of the Committee.

But anyway, the primary strategy that experts talk about—and, boy, there are plenty of them in this league—is to control the growth, to move beneficiaries to managed care plans.

But in my State we do not have any managed care plans. They are starting very slowly. And what about a State like mine—we always do that provincially here—where we do not have an influx of managed care plans? What can be done to bring the States into managed care that have a small number of people? How are we going to achieve cost savings that will bring Medicaid under control, while still providing the services to the most vulnerable in society?

Perhaps Dr. O'Neill could answer that question, or Dr. Wilensky.

Dr. O'NEILL. Wyoming, as best I can tell from my chart, is a State that has a lower share of Federal expenditures than it does of the poverty population. But the percentage is one-tenth of 1 percent of Federal expenditures.

In that way, you seem to be not only a small State, but you seem to get less than your share of Federal dollars. So yours is probably one of the States that is more careful in its spending than others.

Copayment, however, is an issue that depends on what context it is raised in. I would not be surprised if, under a block grant system, and if States were given flexibility, that they would charge copayments, particularly to Medicaid recipients whose incomes were above the poverty level.

But in the context of the current system, if the Federal Government prescribed copayment it is difficult, to know exactly how that would work out. A lot of it is for long-term care, and I was not exactly sure of the context in which you were, raising the question.

Senator SIMPSON. My time has expired, doctor. I will submit some questions in writing. I too have another hearing.

But thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you.

Each of you indicated that there is some cushion in this system because of the States gaming the system, especially on disproportionate share hospitals. How much of a cushion, Dr. O'Neill, I will start with you? This is not a policy question, this is a factual question.

Dr. O'NEILL. How much cushion is there?

The CHAIRMAN. Each of you, in one way or another, indicated in your statements that by using provider-specific taxes—and especially with disproportionate share hospitals—they had built in a cushion. Do you have an estimate of how much?

Dr. O'NEILL. No, I do not. It is probably difficult to make such an estimate because we do not know much about where the disproportionate share money actually went or how much of it. But I would be happy to find out for the record.

[The following information was subsequently received for the record:]

In response to the Chairman's request for an estimate of the size of the financial cushion that was built into the Medicaid program through provider-specific taxes, the August 1994 report of the General Accounting Office indicates that state financing schemes prevalent in the late 1980s and early 1990s resulted in federal matching payments for what were often illusory Medicaid expenditures. A fall 1994 study by the Health Care Financing Administration (HCFA) showed total reported Medicaid expenditures (federal plus state and local expenditures) of $116.9 billion in fiscal year 1992. HCFA indicated that almost $9 billion of that total represented Medicaid disproportionate share payments to hospitals (DSH) that were offset by donations and taxes paid by the same facilities. Federal DSH payments in that year were estimated at $17 billion by the Urban Institute. HCFA reports $108.0 billion in total Medicaid expenditures in the National Health Accounts for calendar year 1992.

Congressional restrictions enacted in 1991 and 1993 reduced the growth of DSH payments, beginning in 1993. Federal DSH payments in fiscal year 1995 are estimated to be $8.5 billion. We are unable to estimate how much of this amount represents a financial cushion for the states.

The CHAIRMAN. Dr. Rowland?

Dr. ROWLAND. We know there is about $10 billion in Federal disproportionate share payments alone. And we know that they are distributed mostly across 15 States. So one of the things one could clearly look at is allocating that amount of money separately from the other spending on Medicaid.

In fact now, when we look at Medicaid expenditures by population group, we separate out disproportionate share payments. They account for about 14 percent of Medicaid spending, and clearly represent an area where one could have a different distribution of funds, perhaps more targeted toward the poverty population, or toward children, or some other measure for care of the uninsured. These funds are not now distributed by the number of people who are uninsured in the State.

The CHAIRMAN. Dr. Wilensky?

Dr. WILENSKY. My guess—and that is all it is—is that we may be talking about $10 billion to $20 billion which we do not know what happened to it. We do not know whether it was really spent on health care. There were stories raised during the height of the provider tax donation schemes that were being done that indicated States were using these Federal dollars for highways, for education, for funds that had nothing to do with health care.

I used that number because I think a large part, most of the disproportionate share money, falls in that category. But, as I mentioned earlier, I think we do not understand what is going on with the use of intergovernmental transfer money to match Medicaid dollars. That is a big, suspicious area, as to whether it is really new money that is going. If it is only Federal money that is coming in, we do not know exactly where it is going.

Medicaid and HCFA, by its requirements, does not get a lot of information about what the money is actually spent on, let alone what it actually does. However, I agree that surveys have indicated that people have been better off, but not because of HCFA data or State information that is made available to HCFA.

So, if you wanted a ball park number, I would say it is as high as $10 billion to $20 billion. It is of questionable use to the program, as it is now constructed. It may be money well spent on non-health services, which I think is at least part of the time. But it is a big amount that goes beyond disproportionate share spending.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. Yes, sir. I would like to apologize, and report that West Virginia, according to the energetic, systematic efforts of its two Senators, ranks seventh in the balance of payments from the Federal Government.

The CHAIRMAN. You mean they get a lot more back than they pay in?

Senator MOYNIHAN. A lot more back, and they do not have one Air Force base that I am aware of. But they may yet. [Laughter.]

The CHAIRMAN. They do have the Cardinal train.

Senator MOYNIHAN. They have that, sir, and other amenities that are only owing to them. And I wish them all the luck.

It is Virginia that really does the best, because of all those Federal employees. And after Virginia, you have Maryland. Virginia is 4. North Dakota is 5—they have missile sites. [Laughter.]

The District of Columbia is first. Oregon is 37th.

The CHAIRMAN. We have no military base either.

Senator Graham?

Senator GRAHAM. Mr. Chairman, I would like to reserve the right to submit some questions for written response.

I would like to use this last round to turn to a question that was raised early on. And that is the issue of monitoring Medicaid expenditures, particularly monitoring on a performance-based standard.

If you were going to structure a set of indicators, based on health outcomes that were related to Medicaid activities by the States, what would you recommend might be written into this current Medicaid reform proposal that could serve as the report card in the year 2000 or 2001, as to what has actually happened in the States as a result of these changes?

Dr. WILENSKY. Well, I am struggling with this as an actuary. I have asked PPRC, as part of their work plan, to look at this issue, and try to have information available before the fall, to try to look at what performance measures, given where the States are now, might be reasonably looked at.

And I think it will be a combination of outcome of process, or access. Because, if you look at immunization rates, which is an issue that is frequently raised, of 2-year-olds and 5-year-olds, you want to look at not only where you are, but you would want to have information from the States about where the low-income children could get immunization available, in terms of giving us some information about whether you have clinics that provide this, whether you have vans, how it is that whatever your rate is, the process piece that goes with it. That would be a combined reporting.

Similarly, if you look at things like the number of pregnant women who have had contact in their first, second and third trimester, you would want to have some information about where that service was available. Because, in all fairness to the State, you want to make sure that if there are low and/or unchanging measures, you want to have an idea about whether the State made access available and individuals, for whatever reasons, have not used it, or whether it was not made available.

And because performance and outcome does not allow you to differentiate, only that something did not happen, when you know that there may be two parties involved, you want to look at both the availability and the actual outcome.

To the extent the State uses managed care, there is a set of measurement—they are called HEDIS. I do not remember what it stands for, but it is a group of managed care individuals and the Government people working together to try to come out with a set of process outcome measures for managed care.

So the States that choose that, you may want to look at whatever measures from the under 65 employed population would be relevant here.

You have to be careful. You do not want to put impossible requirements on the States. And you want to be selective. If you did 6 or 10, I think in the beginning that might be enough. And maybe even saying that the first round is the States have to tell us what they are planning to do. And then they have to tell us how they did it. Now we want to know what you actually had happen as a result of what you did and how well you did it. So that would be sort of a two-prong strategy.

Dr. ROWLAND. Senator, I think it is important to note that over the past years, the only reliable medicaid data we have gotten from the States has been related to payment, data that has to be submitted in order to get their Federal matching funds. Any of the other reporting requirements have been, at best, sporadic.

And to expect realistic data, that is a whole different kind of system than a claims processing and payment system, to come from the States, is going to require a lot of new changes at the State level, in terms of data collection efforts, and a whole different strategy for monitoring their populations.

We have already begun to lose a lot of information in Medicaid on the population served. As people enroll in managed care plans, the States no longer report any utilization data on that population. They just report them as a capitated payment to a managed care plan.

So I think this issue of thinking through what you would require, how difficult it would be to collect, and how to do it, is very important. You may want to think about having specific surveys undertaken on an annual basis in these States, as opposed to 100 percent collection of data.

Dr. O'NEILL. It is certainly true that what has been reported has been extremely perfunctory. And I have often wondered about the accuracy, of unduplicated beneficiary counts and things of that sort. We know very little about these.

But I think that, in exchange for something like a block grant, it would certainly be useful to have more data on the program; basic information such as the income levels and characteristics of the populations that are being served, and some information, as Dr. Wilensky sketched, on basic indicators of utilization.

It would be dangerous to try to tie the funds to any sort of health outcomes, I would say, because there might be some temptation to say that funds should be related to reductions in infant mortality, or something like that.

In fact, a health outcome like infant mortality is certainly affected by much more than medical expenditures. A State could be making every effort, but still, because of particular problems with the populations it serves, could not attain the reduction that would be required.

Senator GRAHAM. I am not necessarily suggesting that you tie the funding to the outcomes. First, you have to think through the difficult intellectual process of what is it you are trying to achieve, how you measure that, and how you appropriately report it.

For instance, in education, there is a national survey done and published periodically at various grade levels on basic educational skills, which serves to force States to look at what they are doing in comparison to other similar States and the nation as a whole. It has served as a constructive motivator for educational improvement.

I would think, if the States had similar type information, relative to the change in health outcomes of the population to which Medicaid is directed, it would similarly serve to stimulate the States for new innovation and evaluation of how well they are using their resources.

The CHAIRMAN. Thank you. I have no more questions.

Doctors, thank you very much for coming this morning.

[Whereupon, at 11:20 a.m., the hearing was concluded.]

MEDICAID: STATE FLEXIBILITY

WEDNESDAY, JULY 12, 1995

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to recess, at 9:30 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman of the committee) presiding.

Also present: Senators Grassley, D'Amato, Nickles, Moynihan, Baucus, Breaux, Conrad, Graham, and Moseley-Braun.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The Committee will come to order. This is the third hearing in this series of hearings we are having on Medicaid, and subsequently on Medicare, in an effort to see if we can possibly meet the budget resolution totals that we have been given.

We have asked the Administrator of the Health Care Financing Administration, Bruce Vladeck, to appear before us today. He comes from a long background in New York and New Jersey before he came here, and knows this subject backwards and forwards.

I think you know what the philosophical issues are—block grants and ending the Federal entitlement versus no block grants and not ending the Federal entitlement. Or, if you have block grants, what strings do you put on them, in which case it is not a block grant. Or, if you keep a Federal entitlement, but attempt to cut back on the strings, will that save money? If you do not cut back on the strings, but do cut back on the money, are the States in the worst position of all?

There is probably nobody who can bring more light—I do not mean heat—to this subject than you, in terms of the waivers, and are they working? Do the States like them, and do the States think they are easy to get, or would they rather go to some system where they do not have to apply for waivers? I think you know the entire gambit, and I look forward very much to hearing your testimony this morning.

Senator Moynihan?

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Mr. Chairman, I would just like to note an event that took place during the Fourth of July recess, out at Jackson Hole, WY. They had an annual meeting of the Jackson Hole

Group which includes persons involved in health care systems, presided over by Dr. Paul Ellwood.

A lead story in the New York Times said that the group agreed that the time had come to start concentrating on the quality of managed care, inasmuch as the costs seem to have stabilized.

Last year, the Times reported that the costs went down 1 percent. This is very much in harmony with the testimony that Dr. Ellwood gave us last year, that we are getting hold of costs. But there are secondary effects, such as what happens to teaching hospitals and the medical schools who provide them with their teaching staff, when pressures created by managed care have the effect of patients not being referred to teaching hospitals?

In New York, we recently learned that Columbia Presbyterian Medical Center is seeking to merge with another hospital. And the College of Physicians and Surgeons of Columbia Medical School, which was chartered by King George II, is also considering joining with another school in response to economic pressures.

So if Dr. Vladeck could comment on these developments in his testimony, we would very much appreciate it. We welcome you, sir.

The CHAIRMAN. King George II being the father of that man who sent the Scots to fight us.

Senator MOYNIHAN. That is right.

The CHAIRMAN. I learn more from Senator Moynihan. He has gotten hold of Thomas Jefferson's first draft of the Declaration of Independence, in which Jefferson is complaining that they are permitting their chief magistrate—this being George II—to send not only soldiers of our common blood, but Scots. That did not make it into the final draft.

Senator D'Amato?

OPENING STATEMENT OF HON. ALFONSE M. D'AMATO, A U.S. SENATOR FROM NEW YORK

Senator D'AMATO. Thank you very much, Mr. Chairman. It is good to see Dr. Vladeck here again.

There are a number of questions that I am concerned about, having to do with the waivers that States seek in order to give them flexibility, the inordinate period of time that the process takes and what, if anything, Dr. Vladeck thinks we could do to move that process, to give flexibility to the States.

Then, of course, I am very much concerned—and I raise this as the Senate is engaged in debating legislation on the floor dealing with regulatory burdens—about the impact of HCFA's new Survey Certification and Enforcement rules. It has come to my attention through a variety of people that these new rules threaten to cause very significant problems in the nursing home industry.

A major concern centers around the new rule's definition of "harm." Now what is harm? The American Health Care Association has conducted a study, and they feel that we are going to be in for some incredible problems, with more than 4,000 facilities—or close to that—nationwide, who will be rated as providing substandard quality of care as a result of this broad definition.

What is harm to a patient? While we want to see that there are good standards that will protect our seniors, I think we have to be careful that we do not plunge the industry into a situation where once again the regulations come down in such a manner that good operators and good facilities fall into this definition of substandard.

I would be very interested in hearing Dr. Vladeck's views on this. What can we do to see to it that there are reasonable interpretations?

And I thank the Chairman for calling this hearing.

The CHAIRMAN. Thank you.

Dr. Vladeck? Go right ahead.

STATEMENT OF BRUCE C. VLADECK, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Dr. VLADECK. Good morning, Mr. Chairman. Thank you for those kind words. I will try to observe your concern about limiting my oral statement. We have submitted a written statement, but I will try to very briefly summarize some of our concerns.

Perhaps the best way to do that is by quickly walking through the series of charts we brought, copies of which, I believe, should be at your places, thanks to the availability of a color printer.

One of the issues with which we want to begin is perceptions about the rate of growth of the Medicaid program, how it compares to the rate of growth for other categories of expenditures, and a particular concern about what years one talks about when one looks at growth rates.

The first chart looks at the annual increases in Medicaid outlays on a per-capita basis, compared to the annual increases in private health insurance outlays on a per-capita basis, over the last 20 years.

If you look at this chart, and project another 10 years into the future, using our projections—although CBO's would shrink the gap between our projections and private sector, but not eliminate it—what you will see is that some very unusual and extraordinary things happened between 1988 and 1991, which are in fact quite atypical for the history of the Medicaid program.

That is to say, throughout its history, except for those years, on a per-enrollee basis, Medicaid costs grew more slowly, or no more quickly than the costs of private health insurance.

A number of things happened during that brief period, of which the most notable was the discovery by the States of ways of using so-called provider taxes and donations in conjunction with disproportionate share payments to hospitals to draw down a significant increase in Federal funds without any significant increase in either State or local contributions.

That is a phenomenon in the magnitude of about $17 billion a year in toto, about $11 billion to $12 billion in Federal share. Congress passed legislation in 1991, and again in 1993, to limit the effects of this phenomenon. As you can see, since that time, the growth rate of the Medicaid program has gone back to that which is quite comparable.

It is not surprising, when you think about the enormous incentives that States, which are indeed required to balance their budgets, have to maintain as low a level of Medicaid spending as they can because of their required share and required contributions to the program.

The other thing I would emphasize is that these charts are on a per-capita basis, and that much of our projection about the increase of Medicaid outlays over the next decade, as you will see in a later chart, is related to the growth in the number of people who would be entitled to coverage under current law, rather than a greater expense per person.

Let me lead up to that with the second chart, which repeats information with which I know the Members of this Committee are very familiar. That is to say that roughly three-quarters of Medicaid beneficiaries are low-income women and children. But, in fact, services for the elderly and disabled account for roughly 70 percent of all Medicaid outlays.

The three-quarters of beneficiaries who are women and children account for slightly under a third of all Medicaid spending. The quarter of beneficiaries who are the elderly and disabled account for 70 percent of Medicaid spending.

Now, of that 70 percent, roughly half is institutional care in nursing homes and intermediate care facilities for the mentally retarded. But the other half—roughly a third of all Medicaid expenditures—are for non-institutional services for the elderly and disabled, including supplementation of Medicaid, the payment of coinsurance deductibles and non-covered services, such as prescription drugs, for the 4½ million Medicare beneficiaries who are also eligible for Medicaid by virtue of their low incomes.

Back to this dynamic of eligibility, let me show you chart 3 very quickly again. What this essentially shows is that while, over the last 5 years, the number of people covered by private health insurance in this country has diminished very considerably, the number of folks covered by Medicaid has grown almost as quickly.

They are not the same people. About two-thirds of the folks who lost private health insurance are adults. More than half of the newly covered folks in the Medicaid program are either children or disabled people who, by definition, are not eligible for employer-based private health insurance because they are outside the labor market.

Nonetheless, we have had an increase over the last 5-year period of roughly 1 percent of the population that is uninsured. What this shows is that, in the aggregate, across the population as a whole, Medicaid has served as a very important safety net. The number of Americans who are uninsured would have grown much more quickly had Medicaid not been available to expand coverage.

I see the red light, Mr. Chairman. May I have about 2 more minutes?

The CHAIRMAN. Go ahead. That is fine.

Dr. VLADECK. Much of the subject of today's hearing is on the issue of State flexibility. It is important to emphasize how diverse and heterogeneous a program Medicaid is. It is hard to capture that in a single visual, but we have tried with the following chart.

As you know, there are certain groups in the population that States are required to cover under the Medicaid program, and other groups in the population they may cover at their option. The income eligibility level for cash assistance is also largely left at the State option.

Further, there are a number of services that States with Medicaid programs are required to cover, and others that they may cover at their option. States are all over the lot in terms of how many of these optional services they cover.

What this chart shows is that only 43-1/2 percent of total Medicaid expenditures for fiscal year 1993 were spent on services States are required under current law to cover, for populations States are required under current law to cover.

More than half of all Medicaid outlays are either for optional services, which States may choose to cover, but are not required to cover, or for populations which States may choose to cover, but are not required to cover under Federal law, or both. Frankly, States are all over the lot in which services and which populations above the Federal minimum they do in fact cover.

Finally, very quickly, the last chart, which speaks directly to the issue that you raised at the outset, Mr. Chairman, looks at the components of projected growth—this is now using CBO numbers and baselines—of the Medicaid program over the next 7 years, and how the expenditure limits in the conference agreement would connect to that.

What this shows in the blue part of the graph at the bottom is that part of the growth in program outlays that is expected to be attributable to increases in the number of covered persons, the number of enrollees. The yellow is the growth in consumer price inflation, and the orange band is the growth in medical price inflation in excess of consumer price inflation.

This shows the extent to which enrollment growth contributes very significantly to the projected growth in total program outlays. And it also shows that the targets in the budget resolution do not cover anticipated enrollment growth plus CPI in any of the years of the budget window. And, of course, that gets tighter in the out years. That is to say that the targets in the budget resolution are less than per-capita increases in inflation, given what we expect will happen with enrollment growth.

This is why we believe that caps of that sort, through a block grant or other mechanism, would make it very difficult for States to maintain the program without significant reductions in the number of people enrolled in the program.

Thank you very much for permitting me to go over the allotted time. I would be happy to take any questions.

[The prepared statement of Dr. Vladeck appears in the appendix.]

The CHAIRMAN. Doctor, as you are aware, the budget resolution passed by the Congress requires us to save $182 billion over the 7 years in the Medicaid program. There is no significant increase, but it is down from baseline.

How much does the President's June budget proposal propose to save in Medicaid over the 7 years?

Dr. VLADECK. Fifty-four billion.

The CHAIRMAN. Now is that off of CBO's baseline?

Dr. VLADECK. That number is a set of savings that we believe are the same policies which produce savings, whether you use the CBO baseline or the President's baseline.

That is to say, the policies we support would produce $54 billion in savings off the CBO baseline, as well as $54 billion in a slightly different configuration off the President's baseline.

The CHAIRMAN. I do not understand that. If you are working off of a lower baseline, which is OMB's lower baseline or yours, and you say we will save $54 billion from that, if CBO has a higher baseline, why do you not save more?

Dr. VLADECK. Well, of course, all of the baselines have various components to them. The President has proposed a reduction in Medicaid outlays through two primary mechanisms. One is a targeted reduction in DSH payments made to hospitals and the Federal share of DSH payments made to hospitals, for which the CBO baseline is actually higher than the President's baseline.

The CHAIRMAN. By about $67 billion, is it not?

Dr. VLADECK. I do not think it is that high on the DSH amount. It is higher, but not by that much.

The CHAIRMAN. All right. Not on DSH, but on all of them.

Dr. VLADECK. On the average, the CBO baseline is higher. But, again, the baseline has a number of components to it.

A major part of the President's strategy has to do with DSH payments, where the CBO baseline is higher than the President's baseline. If you have a per capita cap, then the level at which you have to put the cap does depend on the baseline, but it also depends on how much you can save on the DSH side, where again there are more savings available under the CBO baseline.

The CHAIRMAN. Well, let me put it this way, because I am not following you. Let us say that the administration says we are going to spend $100 billion; that is our baseline. And CBO says $150 billion; that is their baseline. And you say, we think we can save $50 billion from our $100 billion baseline. Why is that not $100 billion saving from CBO's baseline?

Dr. VLADECK. Let me restate that another way. Relative to our baseline, we believe that our proposals would produce savings of about 6 percent in aggregate Medicaid spending over the budget period.

Our arithmetic shows that the budget resolution would reduce Medicaid outlays over the same period, using the Congress' baseline, by almost 20 percent.

We would be happy, although we do not know where we are getting one, to apply a 6 percent reduction to the CBO baseline in the aggregate. However, again, we think that, if you look at the specific policy mechanisms, you produce about $54 billion in savings over the period of time, using the CBO baseline.

The CHAIRMAN. In other words, it does not matter how high the baseline is, the savings are only $54 billion?

Dr. VLADECK. That is what we are proposing, yes.

The CHAIRMAN. I do not follow that. I guess I need some detail. How do you get to your $54 billion?

Dr. VLADECK. Again, there are a number of ways to do it, and how you do it depends in part on which baseline you use.

The CHAIRMAN. I thought the baseline did not make any difference.

Dr. VLADECK. Well, because of the differential growth rates on DSH payments, and the other components, of course. For example, we have proposed a per-capita cap on the rate of growth in Medicaid outlays, Federal payments to States for Medicaid outlays.

The components of the CBO baseline include a slower growth in the number of enrollees than does the President's baseline, and a higher rate of growth per enrollee than the President's baseline.

But we also have experienced—and expect to continue to experience—considerable differences in the rate of growth of per capita expenditures by category of enrollees. That is to say, expenses for the disabled have been growing faster than the expenses for the non-disabled elderly.

As you know, we have not proposed a specific set of policies. There are a number of ways to mix and match specific proposals to achieve numbers in those ranges.

The CHAIRMAN. The President says he will save $54 billion. I have seen the policy statement, but we have not gotten any details yet. You have not gotten any details yet—or maybe you do—but we have not gotten them.

Dr. VLADECK. We do not have a detailed plan.

The CHAIRMAN. All right. How do you know that CBO will not score your savings as greater than your $54 billion if you do not know what they are?

Dr. VLADECK. We never know exactly how CBO is going to score a proposal we make until we make it.

Again, we have run a number of different scenarios with a number of different options, and they tend to produce savings in that range.

The CHAIRMAN. But you seem to think that these savings, once we get the details of whatever they are, will be a reasonably constant $54 billion, plus or minus a margin of error. And the fact that CBO has an immensely higher baseline will not cause them to project the savings as being greater because they are working from a greater baseline.

Dr. VLADECK. Again, we do not know what they would project, but we think they would project a number dramatically smaller than that in the budget resolutions.

The CHAIRMAN. All right. Between your $54 billion and the budget resolutions, where do you think CBO would end up?

Dr. VLADECK. I honestly do not know. We would be prepared to talk with CBO at the appropriate time about a set of proposals that we think would produce somewhere between $50 billion and $60 billion in savings on their scoring.

The CHAIRMAN. When do you think we can have some specifics on the administration's Medicaid proposals? We have to work off of CBO's baseline. And, of course, the President said a year and a half ago that he would work off of CBO's baseline.

But we need those—and we obviously need them relatively soon—because we are working toward an early to mid-September submission of our proposals to the Budget Committee. How soon do you think we could have them?

Dr. VLADECK. I believe the President has said on several occasions that he will be happy to share specific policy proposals with the Congress once the majority has begun to mark up specific proposals.

The CHAIRMAN. But will we have specifics, not just policies?

Dr. VLADECK. That is my understanding.

The CHAIRMAN. All right.

Senator Moynihan?

Senator MOYNIHAN. Your charts, Dr. Vladeck, are remarkably consistent with statements we heard from Dr. Ellwood of the Jackson Hole Group. That first chart shows both private and Medicaid costs in the late 1970's increasing by 16 or 17 percent a year. Of course, there was high inflation at that time.

But now these rates are down. You have Medicaid costs for future years rising at about 2 percentage points above CPI. That is a very different scenario from runaway cost explosion.

Dr. VLADECK. We believe that is still too high a rate, sir. But we do not believe it is out of control at all.

Senator MOYNIHAN. It is not out of control. You would have settled for it, in the 1970's, and you see it growing moderately now.

On the subject of Medicaid as a safety net, we see in your charts an increase in the Medicaid population that almost exactly matches the drop in people covered by employer insurance. But the number of uninsured in 1989 was 16 percent, and the number of uninsured in 1994 is 16 percent.

So all that "the sky is falling" rhetoric seems exaggerated .

Dr. VLADECK. Well, the population is growing, so the number of persons who are uninsured—has grown substantially.

Senator MOYNIHAN. But the percentage has remained stable at 16 percent. And there is no cost explosion. That is good, is it not? Maybe not all we hoped for.

Dr. VLADECK. It could be worse. I am not sure that 16 percent uninsured is good.

Senator MOYNIHAN. No. I am thinking mostly of prices. A measure of price stability seems to be settling into medical costs, both for Medicaid, as well as to the private sector.

You project a sort of stable 2 percent growth rate above CPI for Medicaid. Is that about right?

Dr. VLADECK. That is right.

Senator MOYNIHAN. And then your earlier graph shows us about the growth of private health insurance costs is drifting down to about 3 percentage points above CPI.

Dr. VLADECK. That is true, Senator. I must also add that, on average, that is about the historic rate over the last 20 or 25 years, of CPI plus 2 or 3 percent per capita.

Senator MOYNIHAN. Did we go through an explosion of medical costs between the late 1970's and the late 1980's?

Dr. VLADECK. Again, we particularly went through an explosion in Medicaid.

Senator MOYNIHAN. But in private care?

Dr. VLADECK. In private care, I think it accelerated from the late 1970's through the mid-1980's.

Senator MOYNIHAN. Yes. But it is now reasonably stable, perhaps more than you want, but maybe not more than would surprise you, given the nature of medical care and the advances in medical technology.

Dr. VLADECK. Yes.

Senator MOYNIHAN. Smile. That is not the worst thing you have to live with. It is the kind of thing you can probably handle.

Dr. VLADECK. The implications of that rate of growth, long term—certainly for the Federal budget and for the economy as a whole—is still a great concern.

Senator MOYNIHAN. All right. But let us see, we have GDP growing at about 2.5 percent. If real growth in the cost of Medicaid is about 2 percent, then it closely parallels the growth in national income.

I think that is encouraging. After a year of calamities, forecast daily, it is a rather reassuring indication of stability.

But do you agree that, although other prices may be stable, the cost of maintaining teaching hospitals and the medical schools that go with them, which is where our science comes from, is a problem because those costs are disproportionately high, are they not?

Dr. VLADECK. They are. And it is true that, under that relatively stable growth line, there is enormous dislocation going on in the health care system in many communities, affecting the teaching hospitals and other institutions as well.

Senator MOYNIHAN. And these institutions represent the brain tissue of medicine, if I may say. We are in the great age of medical discovery, and it is coming out of our teaching hospitals and the medical schools behind them.

Dr. VLADECK. As a former member of the faculty of the College of Physicians and Surgeons, I believe these are the very institutions that need to be protected.

Senator MOYNIHAN. Good for you, Dr. Vladeck.

Thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Senator D'Amato?

Senator D'AMATO. Thank you, Mr. Chairman.

Doctor, I know that you have taken the step of recusing yourself, as it relates to the application of New York State for Medicaid waivers. I wish you had not done that. I do not know why you did but, suffice it to say that you have; however, it would seem to me that it would not be necessary, just because you come from a particular State, for you not to be involved. But you have your own reasons, and I respect them.

So let us talk about the generic side of this. I would point out to you that the President issued an Executive Order requiring that waiver decisions—because this hearing is about giving States flexibility—be made within 120 days of the date the State applies.

But I do not think that, from 1994 to date, any application has been approved within 4 months. In fact, approval has taken over 10 months on average. And that is of great concern to many of the Governors, not just New York, because we feel in many cases that, given some flexibility, they can save money. The State can deliver the same kind of services and, in some cases, even enhance those services.

What, if anything, are we doing to try to move this process? I have to tell you that what I hear from our people in New York, it is more delay. We are at the 4-month mark right about now.

Dr. VLADECK. Senator, first of all, it is important to note that most of the waiver applications we have received involve the expenditures of literally billions and billions of dollars of Federal funds over a period of time, a commitment of the Federal Government to commit those funds for an average period of 5 years. And they involve waiver of a number of parts of the Medicaid statute that were expressly put in by Congress because of concern for protections either of the Federal Treasury or Medicaid beneficiaries.

Half of the 1115 applications that have been submitted to us since this administration came into office have been approved within 6 months or less. That average figure is because of several particularly troublesome applications, which have been modified or revised on multiple occasions by the States. Instead of rejecting the old one and starting again, we just keep the clock running.

The fact is that, when we approved the 1115 application in the State of Oregon in 1993, that was the first Statewide 1115 demonstration that had been approved by the Federal Government in 11 years. We have now approved 10 of those applications, and we have several more for which we would expect approval in the next several months.

Six months is still too long. We would like to cut that in half as an average time. On the other hand, as the example of New York illustrates, there are a number of institutions and organizations of constituencies that are quite appropriately concerned about the impact of these programs. We think we have an obligation to hear them out, to learn of their concerns, and to ask the States to address their concerns before we award the States that additional discretion over such a large amount of Federal funds.

Senator D'AMATO. I certainly understand that institutions are concerned, as it relates to how the system might be impacted. But, in fairness, I think when we give approval of a waiver to, for example, a State that wants to bring about managed care, this is with a view towards reducing the cost, both to the State and to the Federal Government. Is that not true?

There are billions of dollars now that are being put into the system, and some people at a local level believe that they can actually do a better job if given some flexibility, and save the Treasury dollars. So I would just like to share that little slice, that perspective, with you.

Dr. VLADECK. Well, absolutely. But New York State——

Senator D'AMATO. I do not mean to be argumentive, but you stressed that this is Treasury and you want to be responsible in the expenditure of money. I think as it relates to many of the States, when they come forward, their programs are not going to cost more. The idea is not to cost the Federal Government more money, but it is to give some flexibility, to give better services, and actually reduce the cost. Is that not true?

Dr. VLADECK. Yes, sir. But, if I may, the State and City of New York, as you know, have just suspended enrollment in Medicaid managed care in the City of New York because of concerns about abuses in marketing under a voluntary enrollment system.

Senator D'AMATO. It seems to me that demonstrates their awareness, and their desire to see to it that these kinds of practices are not undertaken.

Dr. VLADECK. I agree. It also made us feel better about our asking them for more detailed information about their marketing arrangements before we approved their 1115 waiver.

Senator D'AMATO. All right. It is obvious that there is a bona fide concern from the Federal perspective. I hope you share in the awareness that there is also an overwhelming concern on the parts of the Governors that there should be more alacrity and speed, in terms of dealing with these and, obviously, in answering the concerns that you raise. But I think it is appropriate for us to suggest that we do all that we can to facilitate the waiver review and approval process.

It might also be that portions of the waiver be granted, as you work out the difficulties. There probably are vast areas that you can improve—or some areas that you can improve—while you work out the details in the implementation of others.

So I suggest that, while you are not personally involved in the New York situation, this is a grave concern. As a matter of fact, the Governor is coming down today to speak just to this issue.

I thank you.

The CHAIRMAN. Senator Grassley?

Senator GRASSLEY. You stated that the President's proposals for Medicare reforms include per capita limits on Federal Medicaid spending. I think it was just before the July recess, we had a hearing where the point as made that per capita limits would not give the Federal Government the certainty of spending control that block grants would give.

First of all, would you agree with that? Even though you might not like that approach, would you still agree that it would give more control over spending? And, if we do not do that, would not the Federal Government's exposure still be open-ended to some degree where we employ per capita spending limits?

Dr. VLADECK. To answer the first part of your question, sir, absolutely. The tightest control on the Federal outlays would be to define them in advance as a block grant, as being X dollars is all we will provide to the States. And that is a tighter control, a more predictable control than a per-capita cap.

It is exactly because such a predictable defined amount does not respond to changes in economic or demographic circumstances in a particular State, that we believe it would be a very dangerous way to provide Federal financing of the Medicaid program.

What a per-capita cap does is automatically respond to the changes in the number of low-income people in a State, to changes in the number of people without private health insurance in the State, or to other economic or social fluctuations that may increase the need for the availability of the safety net which Medicaid has constituted throughout its history.

So, in a sense, that is the flip side of its being less predictable. However, it does not mean that it is out of control in the sense that, if you actually look at patterns of expenditure growth and enrollment growth on a State-by-State basis, over a period of time, there is a substantial amount of fluctuation, but it tends to be in single-digit ranges.

We are not talking about the Federal exposure doubling from 1 year to the next because a cap is established on a per-capita basis, rather than a full block grant.

Senator GRASSLEY. Well, I would just make a comment that a per-capita limit would maybe limit to some extent, but it would not give us the control that we are going to have to have over these programs if we are going to get them under control, and if we are going to cut down on the impact of the general fund of the Federal Government between now and the year 2002. I want to move on.

Dr. VLADECK. May I add just one comment on that? I believe that we have not submitted it but our perception is, given past experience, that a per-capita cap is just as scorable in CBO terms as a block grant is, whatever the saving is.

Senator GRASSLEY. Well, I think if that is true, then you ought to respond as quickly as you can to what the Chairman requested, that you get your proposals up here.

I would like to move on to something about waivers, not the same waiver that Senator D'Amato was talking about, but I want to talk about 1915(b) waivers. As I understand it, these sorts of waivers have to demonstrate to your agency that access to services and the quality of those services are not compromised.

I would like to have you summarize the experience so far with these waivers, specifically have access and quality been maintained by States with these waivers?

Dr. VLADECK. I would have to answer that by saying that, in general, the answer is clearly yes. All of the studies we have of Medicaid managed care in general show that access has been maintained or improved. Not very many of the studies have measured quality very carefully.

However, we have had a number of problems in a number of States. The prior approval involved in a 1915(b) waiver is not an ironclad guarantee that Medicaid managed care will in fact be of high quality or maintain access.

This is why we are working so hard with the Jackson Hole group and others to quickly and significantly improve our capacity to monitor the performance of managed care plan after a Medicaid waiver or other approval has been granted.

Senator GRASSLEY. Well, then you would probably agree. There is another panelist coming up after you who makes a point in his testimony that these are not particularly strong methodologies.

Dr. VLADECK. The evidence is limited, sir.

Senator GRASSLEY. All right.

In the event that we would liberalize States' ability to require enrollment in managed care services for Medicaid beneficiaries, should the Federal Government retain the quality monitoring function?

Dr. VLADECK. I believe we should. I think there are two issues. First, to the extent that Federal dollars are involved, we have a responsibility for the accountability with which those dollars are spent.

Second, we do have an opportunity from a national level to look nationally at norms and standards of care that are much more difficult to apply in 100 different localities, or 50 different jurisdictions.

Senator GRASSLEY. Also, on quality assurance, in regard to the State of Oregon, the General Accounting Office will be giving us testimony today that Oregon contracts annually with a physicians' review organization to review medical records.

In the administration's view, should the Federal Government require States to use independent review organizations to review the quality of care and access to the care of the State Medicaid managed care program?

Dr. VLADECK. We do now, and we absolutely believe we should continue to do so.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Senator Nickles?

Senator NICKLES. Mr. Chairman, thank you very much.

Dr. Vladeck, what is the difference in total dollars between OMB and CBO for Medicaid for the next 7 years?

Dr. VLADECK. It is about $60 billion, I believe.

Senator NICKLES. Sixty what?

Dr. VLADECK. Sixty or $65 billion over that period of time.

Senator NICKLES. OMB?

The CHAIRMAN. Wait. I am confused now.

Between what—CBO's baseline? I am not quite sure of the question and the answer.

Dr. VLADECK. As I understood the question, it was in total Medicaid outlays between the OMB baseline and the CBO baseline, over the 1996 to 2002 period, we believe it is about $67 billion.

Senator NICKLES. So OMB has a lower baseline?

Dr. VLADECK. No. OMB has a higher baseline. It is about $950 billion, if I remember correctly.

The CHAIRMAN. They have a lower baseline, do they not—OMB?

Dr. VLADECK. I am sorry. It is OMB. I apologize. OMB is about $890 billion over that period. CBO is about $950 billion over that period.

Senator NICKLES. I think that is important.

A couple of comments. One, the President in his 1993 State of the Union address, said that we would use CBO. He got a big round of applause. Some of us met with the President yesterday, and we were talking about trying to reconcile the differences. We all realize that the reconciliation package is going to be the most important thing we do this year. To think that we are this late in the game, and the administration is using difference figures for a baseline, I think that to become relevant in the process, they are going to have to use CBO, or we are going to have to have a concurrence of thought on baseline if we are going to have any bipartisan working agreement.

It is just impossible. With the confusion over what we are doing, and what we are going to be doing in a reconciliation package, I think it is important for us to be together, use one baseline, and speak with one voice and one number.

So I would also say, Mr. Chairman, I hope we use 1995 numbers instead of saying, well, we are reducing the rate of growth of Medicaid by such and such, I would hope we would say on 1995 numbers. Actually, on the proposal we are talking about, we are going to increase Medicaid spending over the next 7 years, compared to the 1995 freeze of $149 billion.

Maybe the administration wants to increase it more. But, if we had used those simple terms, it would make it a lot easier. We should use 1995 figures. Frankly, since we are talking about changing this into a per-capita block grant of some kind anyway, it makes imminent more sense to use the base we are working off of—the 1995—and all move forward.

So, if we are thinking we should spend $149 billion more over the next 7 years, the administration thinks it should be more, that is so much more imminently understandable and less confusing. It would just make things a lot easier for all of us.

Also, would your staff please put up the first chart that you had on annual increase in percentages? I want to again make sure that we are all working off of the same one.

The chart I am looking at, is that Federal Medicaid expenditures you are showing the rate of growth of?

Dr. VLADECK. It is total expenditures, but it does not really matter whether it is total. Federal would only be different if States were growing at radically different rates over time.

Senator NICKLES. Well let me take strong disagreement with that statement. Federal Medicaid expenditures are way off the chart, growth rates. In 1989 they are 13 percent, in 1990 they were 19 percent, in 1991, Senator Moynihan, they are 28 percent, in 1992 they are 29 percent.

They have abated to some extent. In 1993 they are 12 percent, 1994, 8 percent, and 1995, 9 percent. In your statement you mention this because of the disproportionate share, and a lot of States did provider taxes, and so on. But there was a big shift to the Federal Government that we have built into this baseline which I think was really abusive.

So I would like for you to review that chart, or maybe put up another chart that shows the growth in Federal expenditures because we are wrestling with the Federal budget, and we are going to try to reconcile on a Federal budget.

The Federal budget under Medicaid has exploded out of control. It has moderated somewhat in the last couple of years but, when you are looking at growth rates of 19, 28, 19 percent three consecutive years in a row, that is totally out of control.

Dr. VLADECK. But that is no longer permissible under current law.

And again, Senator, I must stress that this is on a per-capita basis. There are 5 million more people covered under the Medicaid program now than there were in 1989. Frankly, our position is that we as a nation would be significantly worse off if those people were uninsured at the moment.

Senator NICKLES. That may be your position. But my point is that I want to be very factual. When we are talking about growth rates, we should all be talking about the same growth rates. Right now we are dealing with the Federal budget. Federal expenditures have been growing out of control, maybe for a lot of different reasons, many of which were Congressionally induced—the disproportionate share program, the provider program. You have a lot of things that happened in those years that greatly expanded expenditures, and we are trying to rein in the growth of those expenditures.

President Clinton told me yesterday that, yes, we realize that we have to reduce the rate of growth of entitlements.

Let me just ask a couple other very quick questions. The number of States that now have managed care under Medicaid?

Dr. VLADECK. I believe it is 48 or 49.

Senator NICKLES. All right.

You mentioned the 1115 applications by States. In many cases, those applications increased the cost to the Federal Government?

Dr. VLADECK. No. We have a rule in our regulations that they be budget neutral over the life of the waiver. I know we have some disagreement with GAO about this but, having been through literally dozens of hours of arguing with the Office of Management and Budget on some of these, I can tell you that it is our belief that every approved 1115 waiver has a set of conditions under which Federal outlays under the waiver would be no greater than they would be in the absence of the waiver.

Senator NICKLES. I thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Breaux?

Senator BREAUX. Thank you, Mr. Chairman. Thank you, Dr. Vladeck, for being with us, and for the good work that you are attempting to do in a very difficult situation. I think that this Committee is faced with some incredible challenges with regard to both Medicare and Medicaid. Two hundred seventy billion dollars worth of Medicare cuts and $182 billion in Medicaid cuts over the next 7 years is going to be a very difficult challenge.

And I think that, in my opinion, block grants are really a divorce from reality. I think that we as a Committee have to make a fundamental decision whether our goal is cutting without caring, or whether it is really to try to reform the system in order to bring about some savings.

I am really concerned that if we do the block grants without any allowance for increasing the number of people in a State who get sick and who are poor, what we are going to do is see an awful lot of people who will not have any insurance at all. And I think that what we have talked about in this Committee is how to get more people insured, not less.

If we cut people off of Medicaid, they still get sick, and they do not have insurance. So we are back to the cost-shifting problem that we have been trying to resolve in an effort to try to get health care costs in this country down.

So, I guess what I want to ask you about is one option that people have suggested—managed care for Medicaid patients as a means of saving. I would like you to comment on that.

I think that in my State of Louisiana, the figures are something like 37 percent of our Medicaid expenditures in Louisiana are for long-term care, nursing home care and home care. I do not know how managed care really helps in that area. I think it may help with a younger population, to give them choices and bring about more competition.

But I am really concerned that with long-term care, home care, nursing home care and elderly care, which is the bulk of the Medicaid population in my State, these options of managed care do not seem to work very well, although I am a big believer in it.

The Arizona case has been cited as a place where managed care has brought about some real reductions in expenditures. I would like you to just comment on what our options are. We just cannot cut and run. Because when we run away from poor people who get sick, we are not doing what we are supposed to be doing as a nation.

So what are our options, and particularly with regard to the managed care option?

Dr. VLADECK. Well, let me start with managed care, if I may. About a quarter of Medicaid beneficiaries in the United States are already enrolled in managed care arrangements of one sort or another.

Senator BREAUX. About a quarter?

Dr. VLADECK. About a quarter. This is about a third of the mothers and kids on AFDC are already in managed care arrangements. And the baseline assumes that by the year 2000, that will be over half.

So whatever additional savings——

Senator BREAUX. Has that contributed to the reduction in the increases in spending?

Dr. VLADECK. To some extent. Yes, sir, we believe that.

Senator BREAUX. So where it has been tried, we have seen reductions in the rate of growth, and that may be one contributing factor to it.?

Dr. VLADECK. That is correct. But, again, we have really taken those savings for about half of the Medicaid population in the baseline.

We have a lot of experience with capitated arrangements for long-term care. And, with the exception of the Arizona experience, we have not shown dramatic savings in any instance. And it is hard to make——

Senator BREAUX. Is there something unique about the Arizona experience, to show the savings they have had?

Dr. VLADECK. Because Arizona was so late in adopting a Medicaid program altogether, it began with a very low supply of nursing homes. Therefore, it was able to build a more community-based system because it did not have to move away from a system that had a heavier preponderance of nursing homes at the outset because the supply of nursing homes was so limited when they put their new system in place.

Other States have tried to build a community-based system for long-term care, of which Oregon and New York just happen to be two of the most notable. They have started from a very large population already in nursing homes, which makes the transition much longer-term.

Senator BREAUX. All right. Do we still realize savings by using an approach that is the per-capita caps as opposed to a straight block grant?

Dr. VLADECK. As a technical matter, sir, one can produce scorable savings, depending on how one sets the caps and how one sets them, of whatever one wants by using per-capita caps as well as by a block grant.

Although, again, the level of certainty is not as great because those caps do adjust for changes in economic circumstances.

Senator BREAUX. Well, there is no question about a block grant if the only thing you are interested in is cutting the budget and cutting people off the rolls. Then block grants work really well.

Dr. VLADECK. Yes.

Senator BREAUX. The question is how many uninsured people do we create in the world? And are we really doing our job, or are we just trying to reduce the amount of money that is spent, without regard to the consequences?

Dr. VLADECK. I agree thoroughly.

Senator BREAUX. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Following on that last point, Dr. Vladeck, what is wrong with capping individual entitlements? I mean, here we are trying to find the best solution to resolve different points of view, and trying to find the greater good for the most people. Obviously, we are trying to cut spending or control spending on one hand, and yet deal with the low-income folks' health care problems and long-term care.

We cannot let perfection be the enemy of the good here. We just have to do the very best we can with what we have got. On the one hand, some people say block grant. Others say keep the present entitlement program.

What is wrong with capping individual entitlements? Is that not probably the best solution between two extremes?

Dr. VLADECK. If by that you mean maintaining the entitlement, but capping the rate of growth on a per-individual basis.

Senator BAUCUS. Correct. That is what I mean.

Dr. VLADECK. Personally, it is harder for both Federal and State managers to have a capped entitlement than an uncapped entitlement.

But, given the need to reduce the budget, it is clearly the best middle ground option.

Senator BAUCUS. And why do you think it is the best middle ground?

Dr. VLADECK. Well, I believe it produces the highest amount of fiscal discipline you can get, without jeopardizing the continued coverage of individuals.

Senator BAUCUS. So, if a new person were to be "entitled", then that person would receive the entitlement, but the dollar payment would still be limited, be capped. They have got some formula here, and I know it would be difficult.

Dr. VLADECK. That is why I say that, in a sense, the per-capita cap puts the burden of achieving the budget target on Federal and State managers rather than on beneficiaries.

Senator BAUCUS. It also avoids the problem of State allocation, the problem that block grants has.

The CHAIRMAN. Not necessarily, does it?

Dr. VLADECK. I believe it solves one of the major—perhaps the major—problem with the allocation formula.

My experience is that there will always be a number of States who, under any set of circumstances, will feel aggrieved by any formula.

Senator BAUCUS. Well, all of us have experienced that phenomenon, and will continue to experience it. But, nevertheless, pure block grants present the problem much more starkly.

Dr. VLADECK. Absolutely.

Senator BAUCUS. Whereas, capped entitlements tend to reduce that problem somewhat.

Dr. VLADECK. Well, they certainly account for all the demographic changes in many of the States.

Senator BAUCUS. All right. Thank you.

The CHAIRMAN. I want to make sure I understand your per capita cap. You mean that to grow as the Medicaid population grows? Or do you mean there will be a dollar amount, and as the number of people grow, the per capita cap will go down to stay within the total dollar amount?

Dr. VLADECK. Sir, the Congress could devise that either way. But our budget options and the options that we have that are not yet proposals all assume that we would seek to attain a growth rate per individual.

The CHAIRMAN. All right.

Dr. VLADECK. So that the total outlays would grow by the sum of the number of newly entitled people plus whatever the cap level was.

The CHAIRMAN. All right. So it is not a limitation on the amount of money in that case?

Dr. VLADECK. Again, back to Senator Grassley's question, it is not a total absolute cap because it does increase as the number of covered persons increase.

The CHAIRMAN. And as the States have a great deal of discretion as to how far they are going to cover Medicaid, to the extent they opt to cover more people, the per capita expenditure is going to go up significantly from the Federal Government.

Dr. VLADECK. Again, the per capita expenditure——

The CHAIRMAN. Assuming that you do the per capita.

Dr. VLADECK. Yes.

The CHAIRMAN. When Oregon went to its Medicaid plan, and went from 60 percent of poverty to 100 percent of poverty, and we had 120,000 people overnight on a per capita cap, you would cover each of those?

Dr. VLADECK. That is correct.

The CHAIRMAN. So it would be a dramatic increase in the amount of money Oregon would get.

Dr. VLADECK. Exactly proportionate to the amount of increase——

The CHAIRMAN. If they choose to cover.

So it is not really an expenditure cap at all. We have enough of a debate on the formula on welfare. When we get into Medicaid, this is welfare in spades, in terms of the formula.

Is it your intention on a per capita cap to give the same amount of money to every person in every State, rather than the allocation we have now, which varies from State to State, depending on whether the State is richer or poorer?

Dr. VLADECK. No. Again, we are talking about a cap in the growth rates, recognizing the very wide disparity that exists at the moment.

The CHAIRMAN. So we still have different Federal spending per individual, depending upon the State?

Dr. VLADECK. Yes, sir.

The CHAIRMAN. Do I take it that you would use pretty much the present distribution formula then?

Dr. VLADECK. The most simple and, in many ways, the most logical way to establish a cap would be to take per capita spending in some base year in each State, and apply a uniform national rate of growth to that.

The CHAIRMAN. You lost me there.

Dr. VLADECK. In essence, yes, sir. You start with what each State is spending per capita, or per category or enrollee, if you did it that way. And then you would establish a national rate of growth ceiling and limit States, each of them starting where they already are, starting from the existing status quo, to a rate of growth that would be uniform nationally.

The CHAIRMAN. And if the State were to reduce its spending on each beneficiary, the State would still get the same matching Federal cap, regardless of how much they spent?

Dr. VLADECK. Well, yes, it would still be a Federal matching. So if the State reduces spending, that would reduce Federal spending, depending on the——

The CHAIRMAN. Well, then you are not talking about per capita Federal cap.

Dr. VLADECK. We are talking about a cap. We are not talking about a per capita allocation. It is a growth rate cap; it is not a fixed sum that is paid to the State, regardless of what happens. We are talking in fact about a growth rate cap, and not about a per-person block grant.

The CHAIRMAN. No. I understand. But wait a minute. A per capita cap, in essence, is that. You have 100 people on Medicaid at a dollar apiece, you give the State $100. They double it, and they have 200 people on Medicaid, you give them $200, if I understand it correctly.

Dr. VLADECK. But if the State reduces the cost per beneficiary to 90 cents, the State only pockets its share of the savings. It does not pocket the whole 10 cents.

The CHAIRMAN. But you continue to give the State a dollar per beneficiary?

Dr. VLADECK. No.

The CHAIRMAN. All right.

Dr. VLADECK. We match under the current formula, up to the cap rate of increase.

The CHAIRMAN. Let me change over to Medicare a minute, as long as you are here. [Laughter.]

I do not know if you remember this, Pat, when Dr. Ellwood was here. Early on, before we really got into the President's health plan, Dr. Ellwood was forthcoming—I do not want to say supportive, but he had a lot of ideas.

But, as he began to watch the administration and watch the Congress, he became more and more skeptical of our passing anything. He said, "I am seeing reform come so fast in the private sector, I am not sure that I want the Government to act in haste." And we certainly did not act at all.

I will be curious to see what he has to say this time because I have been reading those same things you have. And I think we have moved further in the private sector than even he imagined 2 years ago.

All right. You have $128 billion in Medicare savings over 7 years?

Dr. VLADECK. Yes, sir.

The CHAIRMAN. Those are the same kind of ephemeral savings though that are in Medicaid. We do not have any details as to what they are. Will we have those detailed savings pretty soon, and is that off of the OMB baseline?

Dr. VLADECK. We have not had them scored on the OMB baseline. Again, we believe that——

The CHAIRMAN. Well, whose baseline are they scored on?

Dr. VLADECK. They are scored on the President's baseline.

The CHAIRMAN. Is that not OMB?

Dr. VLADECK. I am sorry. I have done that twice now. Yes, they are off the OMB baseline.

The CHAIRMAN. All right.

Dr. VLADECK. We believe they would produce very similar scoring, if one gets down to specific proposals, off the CBO baseline.

The CHAIRMAN. So this is the same answer as for Medicaid. They are not going to save any more money, no matter whose baseline they are off of?

Dr. VLADECK. Again, we cannot say exactly how CBO would score them. But, based on past experience, we think they would score it roughly the same amount.

The CHAIRMAN. Now, you got almost all of your $128 billion from reducing provider costs, or cost growth. They go up, but you reduced the growth. You have almost no increase in beneficiary costs. This, doctor is very critical. How soon will we have that? We are literally going to be into this very quickly.

Dr. VLADECK. Well, again, I believe on all these budget proposal matters, the Administration has taken the position that, once there begin to be specific proposals from the majority in the markup process, we will be prepared to discuss our specifics.

The CHAIRMAN. So we will be operating, however, in the blind as to what yours are until we start the markup? You will give us nothing ahead of time?

Dr. VLADECK. As far as I understand it, that is the current intention.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. Would you mind, doctor, and with great respect, go back and tell Mr. Panetta that that is pretty dumb? With great respect.

Dr. VLADECK. May I say that I am conveying a message from you?

Senator MOYNIHAN. Yes, sir. [Laughter.]

Dr. VLADECK. As long as I can attribute the source, I will be happy to do that. [Laughter.]

Senator MOYNIHAN. You do not need this job. You do not have to worry about that. [Laughter.]

I would very much appreciate if you could give us in writing your view of the per capita capped entitlement process.

I think what you are saying is that you would keep the existing entitlement approach, but limit the rate of growth. This is a system in which only 43.5 percent of the persons covered are covered as the result of Federal requirements which the remainder are covered at the option of the States. In other words, there is a great deal of flexibility in the current system.

Dr. VLADECK. And we would add more flexibility, sir.

[The information referred to above appears in the appendix, p. 278.]

Senator MOYNIHAN. Could I ask one other thing? On that bar chart you have, what portion of the 49 percent Medicaid recipients who are children are also AFDC children?

Dr. VLADECK. I will have to get you the details, but I believe it is roughly half. The remainder would be due to the eligibility expansion since OBRA 1990, and are in families who are not on AFDC, most of whom have a working parent.

Senator MOYNIHAN. Yes. But low-income though.

[The information referred to above appears in the appendix, p. 278.]

Senator MOYNIHAN. So about half of the Medicaid population consists of welfare families?

Dr. VLADECK. If you add those two—and you subtract the other kids, it is about 40 or 45 percent. On AFDC related. Most of the others, of course, are SSI or SSI related.

Senator MOYNIHAN. Thank you very much, sir.

Dr. VLADECK. Thank you.

The CHAIRMAN. Senator Graham?

Senator GRAHAM. Thank you, Mr. Chairman.

Dr. Vladeck, one concern that a number of us have, who favor the goal of greater State flexibility, is that we are going to be giving up a substantial amount of stability in the overall program if we move towards a block grant concept. We would not retain our current ability to respond to economic changes and to demographic changes.

What are the things that the block grant proposal would allow States to do, in terms of shaping the specifics of their Medicaid program, that cannot be accomplished under current waiver procedures?

Dr. VLADECK. Under current waiver procedures, there are a number. Under a block grant, States would be permitted to require copayments of any amount for any category of eligibles, or for any service under a block grant, which we have not agreed to waive.

States would be permitted to sole source contract for managed care, or any other kind of service received under the Medicaid program, without competitive bidding, without any openness in the process under a block grant, in a way that we are not prepared to waive under current law.

Obviously, they could take folks who they are now required by law to cover, where we will not waive that requirement, and cease coverage of them under a block grant.

There are number of particular quality requirements, relative not only to managed care but fee for service care, that we require in the existing program, and that we insist are maintained in all of the waivers. Presumably, States would not be required to maintain these requirements in a block grant.

And there are a whole set of others as well. But I think those would be the most salient.

Senator GRAHAM. So those are all statutory requirements for which current waiver law does not allow administrative modification?

Dr. VLADECK. Either by law or by policy. Generally, by law, we are not permitted to waive any of those requirements I have just listed. Yes, sir.

Senator GRAHAM. Which of those do you think can meet the test of a compelling national interest that would make it inappropriate to allow for State waivers?

Dr. VLADECK. I believe all of those are appropriate national laws.

Senator GRAHAM. Could you give us a list of those items which are currently prohibited from being waived administratively, and do so, first, in the category of those where there is a legal prohibition and, second, where there is a policy prohibition?

Dr. VLADECK. We would be happy to do that.

[The information referred to above appears in the appendix, p. 278.]

Senator GRAHAM. If I could ask, if we could look at the chart, which I think is——

Yes, that is it.

That chart is based on a national profile. Is that correct? Have you done this chart on any State-by-State analysis?

Dr. VLADECK. Neither we nor the CBO project—and these are projected numbers of course—express year-to-year changes at the State level because it is too hard. There is too much variation, and it is too difficult to accurately predict these kinds of numbers on a State-by-State basis.

Senator GRAHAM. But is it not the very fact that it is hard, and that there are significant variations, that make it important?

If you had a State where the blue line—that is, the changing population—was substantially different than the national projection, either greater growth or less growth, would that not have a significant impact on that State's ability, and the fiscal impact on the State's capacity to carry out a health program for low-income citizens?

Dr. VLADECK. Let me agree with you and make sure I correctly understood what you said—that in some States where a block grant with those growth rates in a given year would not cover the rate of newly eligible people, let alone any allowance whatever for inflation.

There would be other States where, for a variety of reasons, there could be an enormous windfall because they ended up covering a lot fewer people and still got that flat national rate of increase.

Senator GRAHAM. And what is your suggestion as to how to deal with those State-to-State variations if we were to adopt a block grant approach?

Dr. VLADECK. I do not believe what is conventionally described as a block grant can ever adequately deal with those State-to-State variations.

Senator GRAHAM. There are a number of States, including the Chairman's State, which have a waiver that particularly allows for a different financial relationship between the Federal Government and that specific State in order to carry out innovative programs.

What would be your recommendation as to how the existing Medicaid waiver should be treated if the program is fundamentally changed, either changed through a block grant or changed through a modification of the current individual guarantee?

Dr. VLADECK. That is a real quandary, sir. None of the existing approved 1115 waivers could survive under the terms of the budget resolution. That is to say, all of them have rates of growth over the life of the waivers which are substantially in excess of the amounts called for in the budget resolution.

And I think that would give the Congress two unpalatable choices. One would be to require the States to modify or discontinue their waivers to meet the amounts permitted under the block grants. The alternative would be to permit those States to continue operating those alternative systems, and even further reduce the amount of money available to States that did not have waivers.

Those would seem to me to be the only two ways Congress could choose to address that problem.

Senator GRAHAM. Since the administration is not bound by the budget resolution that we adopted, and has in fact recommended a substantially lower figure in terms of Medicaid reductions, how would the administration propose to deal with the waiver States?

Dr. VLADECK. We would hope that the Congress will end up with a final budget that permits per capita growth rates such that the existing waivers could either be left intact, or subject to only very minor modifications, which we could negotiate with the States, as is called for in the language of those existing waivers.

Senator GRAHAM. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Moseley-Braun?

Senator MOSELEY-BRAUN. Thank you, Mr. Chairman. Welcome, Dr. Vladeck.

Dr. Vladeck, a study in March of 1995 by the University of Chicago, regarding the Illinois Medicaid program, found that blind and disabled recipients represented some 18 percent of the total number of recipients, but 47 percent of the costs.

So it is obviously more expensive to serve the disabled. But, due to that finding, the University concluded that Medicaid managed care not only would not lead to large savings, but would be a complex and lengthy undertaking.

Based on your review of the available data, what do we know about the cost effectiveness and quality of care in managed care for the blind, disabled and those persons requiring long-term care?

Dr. VLADECK. Very little, Senator. We do have some limited experience with capitated programs for long-term care for the elderly, which have not been called managed care, but which resemble managed care plans in many important ways. And they have demonstrated variable degrees of quality.

But, with the exception of the one unusual circumstance of Arizona, we have never found any savings from any of the other of those programs.

We have almost no experience with managed care—certainly not in Medicaid, and very little in the private sector—from the non-elderly disabled or some of the other categories of persons. So we really just do not know. Given where the money goes for those populations, one could see in principle that savings might certainly be attainable, but there are serious qualitative concerns. And, again, we have almost no experience.

Senator MOSELEY-BRAUN. So a lot of the conversation about the savings in this approach is hypothetical, apocryphal and theoretical, as opposed to anything based on solid data?

Dr. VLADECK. Yes, ma'am.

Senator MOSELEY-BRAUN. Specifically, in my own State of Illinois, in 1991 the General Accounting Office, reviewed our voluntary Medicaid managed care program. GAO found a number of serious problems, including violations by the State of the 75 percent/25 percent rule. There were incentives to under-treat patients, insolvency problems, and a lack of attention to quality care issues.

Two months ago, the Baltimore Sun reported several problems with Maryland's Medicaid managed care program. It went so far as to describe the approaches used for that program as "callous and misleading."

Then, earlier this week, the New York Times reported that HMO's are increasingly denying claims for care provided in hospital emergency rooms, not necessarily limited to Medicaid patients but private pay as well.

If we are going to greatly expand the use of managed care for Medicaid patients, or encourage that expansion, what are some of the steps that you would recommend we need to take to prevent unethical, sometimes illegal, activity?

What kind of safeguards can we put in place to assure that quality of care issues for the disabled, or elderly populations, or children in these Medicaid managed care programs are maintained?

Dr. VLADECK. Senator, I think we need to do three sets of things. First, as was referred to earlier in some of the discussions, we are working very hard with the private sector, and across payers and types of plans, to develop some uniform, widely accepted reporting and accountability standards for all managed care organizations serving all populations.

Second, in reflecting the particular needs of Medicaid populations, and some of the subsets of those needs, we need to do a number of things administratively, in terms of oversight, not only of the quality of care, but of marketing practices, financial arrangements, and things of that sort that build on some of the things we are now doing in some of the States, but that need to be strengthened.

I know that Senator Chafee, Senator Graham and others have been working on some proposals, on which I cannot offer a comprehensive view, but they seem to be the kinds of things we very much need to do.

Third, we also have to find a way to develop appropriate administrative mechanisms that permit consumers in Medicaid managed care a greater voice and a greater degree of control over their own experiences, whether it is building in the appropriate kind of grievance processes or appropriate representation in the decision making. Or, perhaps most importantly, we should continue to give them options for changing plans or changing their arrangements when they are dissatisfied, as we permit in FEHBP and the better private sector arrangements in Medicare.

I think, again, Senators Chafee and Graham, and some of the other Members of this Committee, have been talking about this.

I think all three of those strategies need to be pursued very aggressively because the phenomenon is growing faster than our ability to track it.

Senator MOSELEY-BRAUN. Right. Right.

Well, Senator Chafee's legislation is an important initiative with regard to quality of care issues. Would you be willing to provide us with some written comments about that bill?

Dr. VLADECK. I would be happy to.

Senator MOSELEY-BRAUN. And some input and suggestions even?

Dr. VLADECK. We would be happy to.

Senator MOSELEY-BRAUN. Thank you very much.

Thank you, Mr. Chairman.

[The information referred to above appears in the appendix, p. 279.]

The CHAIRMAN. What did you say New York has done about managed care in Medicaid? Have they discontinued it or stopped selling it?

Dr. VLADECK. They have suspended all new enrollments in Medicaid managed care in New York City, pending——

The CHAIRMAN. New York City only?

Dr. VLADECK. Yes, sir. I believe it is New York City only. This is pending changes in control of the marketing practices by the Medicaid managed care plans.

The CHAIRMAN. Out of curiosity, how do the marketing practices differ? Arizona is almost totally Medicaid managed care. They have 13 companies that are involved, and competing with each other. What is going on in New York City that is unique, that apparently does not go on in Arizona?

Dr. VLADECK. Well, it is not unique because, as Senator Moseley-Braun just suggested, we have had similar problems in California and elsewhere.

Essentially, those circumstances in which plans are permitted and encouraged to market directly to Medicaid beneficiaries, particularly in the so-called voluntary systems, we find a pattern in New York City which has existed in many other States as well. Agents are paid on commission and they turn around and tell clients things that are directly untrue, and they are coercive in their behavior and attitudes towards clients, or they offer illegal inducements of one sort or another to sign people up in the plans.

The CHAIRMAN. Does this happen in Arizona too?

Dr. VLADECK. I do not believe it happened in Arizona. Again, in Arizona there is a more structured, centrally managed process by which beneficiaries choose plans. This is the kind toward which New York is moving, for example, as a way to limit those problems.

The CHAIRMAN. But do they have commission sales in Arizona? What is the method?

Dr. VLADECK. No, I believe it is more like the FEHBP kind of enrollment process, in which each Medicaid person in Arizona is presented annually with the range of choices available to them simultaneously, and they make a selection.

The CHAIRMAN. Thank you. Any other questions of Dr. Vladeck?

[No response.]

The CHAIRMAN. If not, doctor, thank you very much for coming this morning.

Dr. VLADECK. Thank you very much, Mr. Chairman.

The CHAIRMAN. We now move to a panel of Donna Checkett, Robert Hurley, Dick Ladd, Nelda McCall, and William Scanlon.

And we will start with Donna Checkett, who is the director of the Missouri Division of Medical Services, and chair of the National Association of State Medicaid Directors.

Welcome.

STATEMENT OF DONNA CHECKETT, DIRECTOR, MISSOURI DIVISION OF MEDICAL SERVICES, AND CHAIR, NATIONAL ASSOCIATION OF STATE MEDICAID DIRECTORS, JEFFERSON CITY, MO

Ms. CHECKETT. Thank you. Good morning. I appreciate this opportunity to testify this morning about the possibility of a restructured Medicaid program.

I am testifying today on behalf of the American Public Welfare Association. We represent the 50-State human service organizations, and the 50-State Medicaid directors. I am chair of the National Association of State Medicaid Directors, and am also the director in the State of Missouri.

We recognize and appreciate the need for slowing the growth of Federal entitlement programs, including the Medicaid program. And, last week, our association adopted a comprehensive set of recommendations for Medicaid reform. The full text of those recommendations is attached for the record.

First of all, I would like to indicate that APWA has not recommended a specific position on whether or not Medicaid should remain as an entitlement, or whether it should be converted to a State block grant.

There has been a great deal of discussion and interest in State flexibility in the past——

The CHAIRMAN. Can I ask you a question?

Ms. CHECKETT. Yes, sir.

The CHAIRMAN. Is that because the association is split, and you cannot reach a decision?

Ms. CHECKETT. The association is a bipartisan association, and we literally did not take a vote on that issue because we knew that we would not be able to come to that type of agreement.

The CHAIRMAN. All right. Thank you.

Ms. CHECKETT. So it was out of our purview, Senator.

We do have a series of recommendations on State flexibility that I would like to go through briefly.

First, you will not be surprised to learn that we recommend the elimination of the Boren amendment.

Second, we recommend elimination of cost-based reimbursement for Federally-qualified health centers and rural health clinics.

Third, we call for a modification of the OBRA 1989 provisions for early periodic screening, diagnosis and treatment. That is a long name for a well-intended program that has resulted in a package of benefits for Medicaid-eligible children that is absolutely far in excess of that available under commercial insurance.

Fourth, we call for a repeal of all existing limitations on our ability to enroll Medicaid eligibles into managed care—specifically 75/25, but there are others.

And, finally, if Congress restructures the Medicaid program and reduces Federal funding over the next 7 years, then we recommend that responsibility for setting eligibility, benefits and payments levels be given to the States.

The CHAIRMAN. Just out of curiosity, what do you recommend that is not a block grant?

It sounds like what you are suggesting is a block grant in all but the name.

Ms. CHECKETT. Well, I think we have that in our attached documents, and I am trying to stick to my 5 minutes.

The CHAIRMAN. All right. I apologize.

Ms. CHECKETT. And we really have a series of things that we could say. If there would be a total repeal of Title 19, this is what we would do under reductions of $180 billion. And, if not, then here are some minor tinkerings that could be done to the statute.

We do recommend that State allocations be based on expenditures incurred in the fiscal year prior to the enactment of Medicaid reform.

We certainly believe that the rates of growth need to be higher in the first several years, in order to assist States in making the transition to a restructured Medicaid program.

We have a suggestion for something that I have not heard from others. That would be the establishment of a bipartisan commission to make recommendations to Congress regarding adjustments to the State baseline years for Federal payments from fiscal years 1998 through 2002.

So, in other words, for 2 years the States would operate on their current baselines, and there would be reevaluation to look at various factors and differences among the States. As you know, there are great differences in spending and coverage among the States.

We certainly recommend that the Federal requirements regarding current waivers be repealed, specifically 1915(b), which are freedom-of-choice waivers, 1915(c), which are home and community-based waivers, and the 1115 State reform waivers.

We also recognize that States will need to have some type of contingency fund to tap in cases of severe economic downturns and national disasters. And we would specify that this be funded separately from the current allocations for Medicaid.

There is one area that I would like to really focus your attention on. It is of great concern to the States. And that is the complicated interrelationship between Medicare and Medicaid. Right now, both of these programs provide funding in various ways for really the most expensive, costly and usually highest need people in our country.

Medicaid programs have the additional Federal mandate to pay for the copayments and premiums for Part A and B for low-income elderly and disabled. We fear that, if Congressional Medicaid reductions are achieved by increasing beneficiary cost-sharing, some of the Medicare savings could result in increased Medicaid costs because Medicaid will wind up paying for those increased premiums and deductibles. This is simply an unacceptable cost-shift to the States. We are extremely concerned about that.

However, the implications of Medicare changes and Medicaid go beyond the issue of copayments. Again, these are two major programs, designed to support the most expensive people in the country.

For example, thousands of frail elderly receive hospital care and physician care through Medicare, but Medicaid pays for nursing home coverage, pharmacy, home and community-based services.

But the two programs operate on two separate tracks. They have different funding sources. They have a different administration and, in the House of Representatives, even two different authorizing committees. There is literally no single entity that is coordinating the care and the funding for the most expensive people in our Nation's health care system. And we really ask you to look at that.

We believe that we need the flexibility to manage these individuals, to put them into a managed care setting. And I really feel, in addition to the fact that it is fiscally irresponsible for us not to be able to do that, it literally results in systems of care that are bad for people. If I had time, I could walk you through and show you how this happens. And it really does need to be addressed.

I know I am almost out of time. Obviously, transition issues are major concerns for States. I speak to many legislative committees in my own State of Missouri, and they want to have a lot to say about Medicaid restructuring as well. And we cannot do it overnight.

We certainly ask that you recommend or realize that we need the ability not to be worrying about Federal sanctions and fiscal sanctions, particularly during our transition period.

In conclusion, I would like to say that Medicaid is the safety net for the poorest and most vulnerable in our country. I am very proud of the program. I suspect people rarely come in and tell you what a good program it is. It is a good program. We do a lot of good things. I also realize that the whole country is in a real dilemma about the cost of it.

And we really do want to work with you and support your efforts. We certainly will do so, but we must have flexible tools, adequate funding and an appropriate transition period.

I thank you again for this opportunity to testify.

The CHAIRMAN. I apologize for interrupting you. You would have made it within your 5 minutes if I had not said anything.

Ms. CHECKETT. I practiced.

The CHAIRMAN. Next, we will take Dr. Robert Hurley, who is an associate professor in the department of health administration at the Medical College of Virginia in Richmond.

Doctor?

[The prepared statement of Ms. Checkett appears in the appendix.]

STATEMENT OF ROBERT E. HURLEY, PH.D., ASSOCIATE PROFESSOR, DEPARTMENT OF HEALTH ADMINISTRATION, MEDICAL COLLEGE OF VIRGINIA, RICHMOND, VA

Dr. HURLEY. Thank you, Mr. Chairman.

I have spent the last 11 years examining the growth of managed care in Medicaid across the country. And much of what we know about this development has come through the use of the 1915(b) waiver authority, which I will speak to.

This authority has enabled the States and HCFA to accumulate substantial diverse experience with many forms of managed care. These waiver applications have typically requested relief from several requirements, but by far the most common feature waived has been the freedom of choice of provider.

This has permitted Medicaid beneficiaries to be mandatorily enrolled with primary care physicians, or in HMO's or other prepaid health plans.

The range of variation has been enormous, not inconsistent with the intent to promote creativity and ingenuity.

HCFA has orchestrated and modulated this waiver process by enforcing a kind of "first do no harm" oversight role, wherein States have to demonstrate that no harm is done, either budget-wise or beneficiary-wise. Budgetarily, States must demonstrate that the managed care programs do not result in increased cost. Beneficiary-wise, they must demonstrate that prior levels of access and quality have not been compromised.

HCFA has required States to have periodic external assessments to determine if the program succeeded in both of these ways, as a condition for waiver renewal.

We have conducted some of these assessments, and reviewed many more of them. The results suggest that credible savings ranging from 5 to 15 percent in these programs can be documented without adverse access or quality consequences.

Senator MOYNIHAN. Five to 15 percent?

Dr. HURLEY. Fifteen percent.

In truth, however, the 1915(b) waiver studies are not especially strong methodologically, as Senator Grassley suggested from my comments earlier. And States are mainly intent on proving that savings have been achieved to ensure that their waivers are renewed.

I mention this to contrast these studies with the 1115 research and demonstration waiver evaluations, which are more rigorous, and thus more reliable.

Despite our extensive knowledge about the 1915(b) wavier experience, I suggest that we should be cautious in extrapolating from it. Revolutionary changes are occurring in the health care marketplace that are profoundly affecting Medicaid today.

These changes are creating historic opportunities for State agencies to use beneficiary lives for leverage in their negotiations with managed care plans to obtain price and service concessions heretofore viewed as unattainable. Thus, we are really into uncharted—albeit promising—territory for waivered managed care programs.

Let me give you three quick examples. In several metropolitan markets today, we have well established HMO's who are bidding or competing to enroll Medicaid beneficiaries for the first time because Medicaid recipients now represent an attractive and underdeveloped market for them.

In some mature markets, where enrollment has already been occurring, States are receiving renewal bids that are equal to, or even less than, bid prices from previous years.

Finally, we have in a number of markets established managed care plans paying rates to their network providers that are the same for commercial and Medicaid enrollees, suggesting the achievability for both mainstreaming and payment parity, two of the most elusive goals of the Medicaid program.

But I would be remiss if I did not share some notes of caution with you. First, most of our experience with Medicaid managed care under these waivers has been with the AFDC population, as has already been pointed out. We do not know whether enrollment of the aged, blind and disabled in managed care on a mandatory basis is administratively feasible, clinically suitable or economically desirable.

Arizona is the only State which has yet to both do this and to have it carefully evaluated.

There are many reasons why what we know from the AFDC experience in managed care cannot be generalized to the rest of the Medicaid population which, as you have already discussed this morning, now consume the preponderance of program expenditures.

The second caveat deals with the impact of rapidly expanding mandatory managed care on safety net providers, meaning those which provide a substantial amount of the care to the uninsured.

These providers are finding it extremely challenging to make themselves attractive to managed care networks. Even if they succeed in doing so, they are hard pressed to obtain payment rates that produce the surpluses needed to cross-subsidize services to the uninsured, as they have done in the past.

Unless States find ways to cover the uninsured, and to enroll them in managed care programs, as only a very few have done, I believe we could precipitate a crisis situation where there will not be enough safety net providers capable of serving the uninsured in many urban areas.

My final concern relates to where the locus of beneficiary protection will be if the oversight or stewardship role of HCFA is greatly diminished. I say this because there is currently extreme variation among the States in their capacity to develop the purchasing competence needed to meet beneficiary needs in the managed care world.

If we too rapidly shift financial risk to beleaguered and overmatched States, the first do-no-harm dictum may be applied only to the budgetary concern of living within the constraint of no additional State expenditures.

In a block granted environment, for example, it is hard to see what agencies within State government will have sufficient independence to vigorously and vigilantly promote beneficiary protection.

Thank you for the opportunity to speak. I would be glad to respond to questions at the appropriate time.

The CHAIRMAN. Doctor, thank you very much.

[The prepared statement of Dr. Hurley appears in the appendix.]

The CHAIRMAN. Next we are going to take Richard Ladd, who currently is the president of Ladd and Associates in Austin Texas. But I have known Dick Ladd for the better part of 15 years. He used to be the administrator of the Senior and Disabled Division in the State of Oregon until we lost him to Texas in the same position, which was a gain for them and a loss for us.

The thing I most remember is that it was with Dick Ladd that we got the first waiver, as I recall, for Jackson County, Oregon to attempt to experiment with Medicaid funds for home and community-based care rather than nursing homes. It was like pulling teeth to get the waiver for one county. And then we subsequently got it for the State of Oregon, and we were able to just about double the number of elderly we were able to take care of with the same Medicaid funds, using home and community-based care.

I am not sure we started out any different than the national average when we started. And the national average for long-term care today is 84 percent if its nursing homes, 16 percent if community or home-based in Oregon. Instead of 84 percent, it is 53 percent in nursing homes. So it has taken us about a dozen years to get there, but Dick Ladd was the reason we did get there.

Dick, good to have you with us.

STATEMENT OF RICHARD C. LADD, PRESIDENT, LADD AND ASSOCIATES, AUSTIN, TX

Mr. LADD. Thank you, Senator. It is a pleasure to be here again this year. And I am planning on going back to Oregon. In fact, I would go back now if you would change the law on capital gains when you sell your house. [Laughter.]

The CHAIRMAN. We will call you back as a witness when we get to the tax part.

Mr. LADD. I would like to speak today mainly about long-term care, that portion of Medicaid that goes to long-term care. It represents about 40 percent of Medicaid expenditures. And, as you so well stated, nursing homes are the biggest part of that. Eighty-four percent goes to home and community-based care.

Nursing homes are the most expensive long-term care provider that we have. And that raises some questions that are continually asked. And that is, is this the best way to spend these dollars? Is there a better way to do so? Well, Oregon and New York are two States that have found better ways.

We just completed a recent study with the University of Minnesota concerning a number of statistics around long-term care, and then made some judgments on those. We determined that the most progressive models in the country were probably Oregon and New York, and the least progressive were probably the District of Columbia and the State of Mississippi, in terms of how committed they were to getting a balanced system where you have more home and community-based care, not nursing home dominated.

We assume that is the appropriate way to go, and certainly that is the way that study after study tells us that the senior and disabled folks want. They do not want to be institutionalized unless that becomes absolutely necessary.

The question then rises, what is the percentage of long-term care clients that should be institutionalized? And that varies from State to State. If you look at the State of Oregon, which has the lowest in the country, only 22.7 percent of all the long-term care clients are in nursing homes.

On the other end of the spectrum, if you go to Mississippi, you find that almost everybody is in nursing homes. They only have about 200 or 300 in the community, in a State similar sized in population to Mississippi and Oregon.

At current rates, what is happening in Medicaid long-term care is that the home and community-based care program is growing about 1 percent a year. We expect to spend 18 percent next year, and nursing homes will be at 83 or 82 percent. If that continues, the country as a whole will reach the point that Oregon is right now in 33 years.

So, again, three questions come up from this information. Should States provide a more balanced, more user-friendly long-term care system? And I think the answer to that is yes, they should, if that is possible. That should be done. What is needed to encourage States to do so? I will skip that just for a second and go to the third question, which is, will such a system save or cost additional money, which is very important right now?

The answer to that question is, it should cost less. If you look at long-term care, Medicaid per capita spending, or total per capita spending—in other words, take the dollars that are going to long-term care, divide that by the aged 65 plus population, the total, so you get a standard—what you find is that the State that spends the most, the State of New York, the State that spends the least, the State of Arizona, the national average is $896. Oregon is in the lower part of that at $732.

So by diverting the system in Oregon, and going to 22 percent nursing home care and 78 percent home care, the total cost per capita is lower than the national average by doing this.

Now that second question is how do you get from here to there? To encourage States to do this is more difficult. And it is harder for States to do.

For the last 7 years or so, since the Federal Government became more flexible with home and community-based care waivers, States have had the opportunity to expand those programs if they so desire. Unfortunately, very few States have done so.

In Texas, for example, in 1993, we were able to get a 22,000-person waiver in less than 3 months from the Federal Government. But we were not able to implement it. The reason was because it was bad for nursing home business. We had a meeting in the Lieutenant Governor's office, and the program was stopped. And we were only able to implement 3,000 of those 22,000.

I have visited 27 of the States and talked there. over the years, I have probably met everybody in the country who is involved in long-term care in the States.

In that experience, the one thing that comes out of it more than anything else is that the States want to move in this direction. But, when it gets down to doing it, it is very difficult because it is bad for nursing home business, and nursing homes are quite powerful in every one of those State legislatures. So it becomes very difficult to do.

To sum up before that red light goes on, my recommendation is managed care for long-term care. I think that is the answer. I think we can learn a lot from Arizona. Now, obviously, Arizona is a special case. But I think there is a lot to learn there. Minnesota right now has 1115 to do the Statewide on long-term care. They have not gotten started on it, but I think there is a lot to learn there.

I am convinced that managed care is the way to go on long-term care. In 1982, Congress made a major step when they went to progressive reimbursement for Medicare and hospitals. I think it is about time we did something like that for long-term care.

The CHAIRMAN. Thank you very much, Dick.

[The prepared statement of Mr. Ladd appears in the appendix.]

The CHAIRMAN. Next we are going to take Nelda McCall. We have heard Arizona, Arizona, Arizona all day. She has been the project director on two evaluations of the Arizona health care cost containment system for HCFA. So there is probably nobody who can better tell us if it works, why it works, how it works, than Ms. McCall.

Ms. McCall?

STATEMENT OF NELDA McCALL, PRESIDENT, LAGUNA RESEARCH ASSOCIATES, SAN FRANCISCO, CA

Ms. MCCALL. Thank you very much, Senator.

As you suggested, my remarks are going to focus on the Arizona Health Care Cost Containment System, I have been the project director of two evaluations of the program for the Health Care Financing Administration.

Arizona has never had a traditional Medicaid program. In 1982, it received an 1115 waiver to operate a capitated managed care Medicaid program. Initial implementation did not include long-term care services. Long-term care was added to the program in 1989.

Currently the State still operating under an 1115 waiver, provides services to 450,000 beneficiaries. All Medicaid eligibility groups are covered, including women, children and the elderly and disabled.

The acute care program serves most of its 430,000 beneficiaries through 13 health care plans, selected through a competitive bidding process. All beneficiaries in the State have a choice of more than one health care plan.

The long-term care program capitates contractors to provide acute home and community-based and institutional services to 20,000 beneficiaries, determined by the State to be at risk of institutionalization.

Contractors include 5 counties, 2 private contractors and the Arizona Department of Economic Security. Beneficiaries are placed in home care or in nursing homes. Capitation payments are structured to provide incentives to serve eligibles in home care.

Let me briefly review some of our evaluation findings. In all of the analyses I am going to be talking about, except the cost analysis, the comparison group is New Mexico.

With respect to the utilization of medical care services, Arizona beneficiaries have fewer hospital days, less procedures, more evaluation and management services. The intensity of service use is similar, but the pattern of use shows a distribution deemphasizing the use of institutional services and specialty care.

Two reviews of medical records were done as part of our evaluations. Findings from a review of children's and pregnant women's records 3 years after the start of the acute care program showed that care for children was in greater conformity with generally accepted American Academy of Pediatric guidelines.

With respect to maternity care, pregnancy care and pregnancy outcomes were similar, but Arizona had a smaller number of prenatal visits.

Review of nursing home records of Arizona and New Mexico beneficiaries for care received in the second years of the long-term care program indicated that quality was poorer on some measures for Arizona beneficiaries, and similar for other measures.

Although these findings highlight areas of concern, it is important to note that they are for early implementation periods and, in addition, the problems identified were taken very seriously by the program's administration, which has initiated steps to include assessments of these areas in their ongoing quality assurance activities.

A household survey of acute care beneficiaries found access to routine medical care better. Beneficiaries' use of medical care for particular symptoms indicated that they were getting desirable levels of care. Satisfaction levels were also high on seven specific elements of care.

We followed new admissions to the long-term care program, and found a much more coordinated system of care.

And our studies of the cost effectiveness of home care have indicated that being able to divert beneficiaries from long-term care to home care has proved to be cost-effective in Arizona.

The cost analysis of the acute and long-term care programs indicates cost savings for the programs, compared to traditional programs. The acute care program averaged a 7 percent per year savings over the first 11 years, with larger savings found in the last 5 years of the program.

The long-term care program savings are estimated to be 17 percent per year, again with cost savings higher in the later years—rates of about 21 percent.

In summary, the Arizona health care cost containment system has demonstrated success in a number of important areas, and has the potential to provide better access to quality health care at lower cost.

Based on my experience, it seems clear that States can have good ideas, and can do a good job in implementing innovative programs. This should help alleviate some concerns about giving States flexibility in design coverage and reimbursement issues.

However, States can be more effective, and can demonstrate their effectiveness more concretely if there is Federal involvement to provide support to ensure accountability in the following areas: Standardized reporting of utilization and program costs; technical assistance on issues of program implementation, including the development of administrative infrastructure and quality assurance; coordinating and funding studies to assess what works and what does not; and providing a forum for the sharing of ideas among the States.

I would be happy to take questions.

The CHAIRMAN. Thank you very much.

[The prepared statement of Ms. McCall appears in the appendix.]

The CHAIRMAN. And we will conclude this panel with Dr. William Scanlon, who is the Associate Director, Health Financing, for the General Accounting Office.

Doctor?

STATEMENT OF WILLIAM J. SCANLON, Ph.D., ASSOCIATE DIRECTOR, HEALTH FINANCING, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Dr. SCANLON. Thank you, Mr. Chairman, Members of the Committee.

I am pleased to be here today as you consider the question of State flexibility to pursue innovative restructuring of their Medicaid programs.

This hearing comes at a time when the Congress is searching for ways to slow Medicaid spending growth. In response, many Governors are asking for authority to initiate cost conscious innovations without the burden of seeking Federal waivers.

My comments today are going to focus on the existing authorities to waive Medicaid managed care restrictions, the purpose behind such restrictions, the need for oversight in their absence, and our concerns about the impact of recently approved waivers on Federal Medicaid expenditures.

I will also comment on the separate authority that allows States greater latitude in the provision of home and community-based long-term care services.

The Medicaid statute drafted in the mid-1960's reflects a bias toward the state-of-the-art health care delivery system of that era. The health care system has evolved considerably since then. Unrestricted choice of providers, reimbursed on a fee-for-service basis, has been superseded in importance by a continuum of managed care delivery systems.

In 1993, about 60 percent of individuals with employer-purchased health insurance were in some type of managed care plan. In contrast, at the same time, only 14 percent of Medicaid recipients were enrolled in managed care.

To mandate enrollment of Medicaid recipients in a managed care plan, a State must obtain either a 1915(b) or an 1115 demonstration waiver, with the latter providing the most flexibility, in terms of implementing a managed care program.

While waivers are available, applying and reapplying can be a time-consuming activity. Furthermore, States believe provisions of the more readily available 1915(b) waivers inhibit implementation of broader managed care plans.

Medicaid's restrictions, however, on the use of managed care reflect historical concerns over quality. In the 1970's, reports on quality of care problems in HMO's prompted the Congress to enact certain provisions intended to ensure that health plans provide public clients the same standard of care available to private clients.

Beneficiary protections are essential because of the financial incentive to underserve inherent in managed care plans that are paid on a per capita, rather than a per-service basis.

Large private sector employers are recognizing the importance of adequate oversight, and are demanding strong quality assurance systems.

HCFA also seems cognizant of the need for adequate oversight. In agreeing to waive some of the traditional quality assurance requirements, it has required States to operate alternative quality assurance systems.

States can also indicate their commitment by the resources and effort they devote to implementing and operating their oversight functions.

While the recently approved 1115 waivers will allow States to move aggressively into managed care, and to cover several million of their uninsured, we are concerned about what these steps might mean for the Federal Treasury.

The administration, as Dr. Vladeck has indicated, has given the Federal stamp of budget neutrality to all approved 1115 demonstrations, asserting that they will cost no more than the continuation of the smaller pre-waiver programs. We disagree.

Three of four approved 1115 waivers that we examined in detail provide access to additional Federal Medicaid funds to help finance State coverage expansion goals. Only Tennessee's demonstration would cost no more than the continuation of its smaller pre-waiver program.

Though the net additional Federal funding is small, relative to overall Medicaid spending, Federal Medicaid costs could grow significantly if the administration shows similar flexibility in reviewing additional waivers.

We believe that the granting of additional 1115 waivers merits further Congressional scrutiny. Even if the proposed demonstrations did not require new Federal dollars, the administration's approval of coverage expansions means that the anticipated Medicaid savings from managed care will not be available to reduce Federal spending.

At issue is whether the U.S. Treasury should benefit from these savings, and whether eligibility should be made available for new groups, only after Congressional debate and legislative action.

Finally, let me turn to the question of long-term care. While most attention today is focused on the use of waiver authority to increase the use of managed care within Medicaid, the significant changes in the delivery of long-term care brought about by the section 1915 (c) and (d) waivers for home and community-based services should not be overlooked.

Prior to 1981, Medicaid long-term care was almost exclusively nursing home care. While States had always been allowed to offer home care benefits, they were concerned that offering such services as an entitlement to all eligibles would result in unacceptable increases in costs as home care. They feared that home care, rather than serving as substitute for nursing home care, would be used by many persons who would never have entered a nursing home, and thereby add cost, rather than helping control long-term care costs.

With 1915 (c) and (d) waivers, States have the ability to target services on particular groups of persons and place limits on the total amounts of services to be provided. This waiver authority has considerably altered Medicaid long-term care

With 49 States having 207 waivers targeted on different segments of their long-term care populations, spending on home and community-based services has become one of the fastest growing components of the Medicaid program. However, as you have heard, it still represents a small fraction of long-term care.

Furthermore, this rapid growth of home and community-based spending, rather than being a source of concern to States, is actually part of State strategies to expand services while controlling overall long-term care costs.

Last year we reported on the successful experiences of the States of Oregon, Washington and Wisconsin, who all have devoted a considerable amount of effort to increasing their funding of home and community-based services and limiting their number of nursing home beds.

While, nationally, the number of nursing beds increased 20 percent over the previous 10 years in those three States, there was an actual reduction in the number of nursing home beds over the prior 10 years.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you have.

The CHAIRMAN. Doctor, thank you.

[The prepared statement of Dr. Scanlon appears in the appendix.]

The CHAIRMAN. Ms. McCall, let me start with you.

Arizona almost seems like Shangri La. You have got almost complete managed Medicaid coverage. You are having good cost savings, and they do not seem to be just in the first 2 or 3 years. This is one of the raps on managed care. They can squeeze money early, but then pretty soon you reach a base where they cannot get any more. Yet that does not seem to be the conclusions that you reached in Arizona.

Then I was intrigued, although you did not touch upon it, that the Arizona Medicaid recipients seem quite satisfied with the system. You have got customer satisfaction in addition.

Can you elaborate? Was it just that Arizona started late? Is that why they have been so successful? Or is there something from Carl Hayden's central Arizona water project?

Senator MOYNIHAN. And do not forget Barry Goldwater. [Laughter.]

The CHAIRMAN. What is the secret?

Ms. MCCALL. Well, those of you who have followed it for a long time probably know that Arizona was not such a big success at the very beginning of the program. Arizona had a difficult time implementing the program, and the first 5 years were actually difficult for the program.

I think that the experience from Arizona shows two things that I hope everybody will understand. First, developing the infrastructure to run a Medicaid managed care program requires some upfront investment.

So I am actually not expecting to see large early cost savings for these States because if they are really going to do a good job at securing providers and enrolling beneficiaries, and setting up systems to collect data, and worrying about quality assurance and consumer satisfaction, they are going to have some implementation costs that will limit the amount of cost savings they are going to have initially.

The CHAIRMAN. Let me ask you, if I might, Dr. Scanlon indicated that Oregon had done all of that before we got into our Medicaid system. We had gone through 5 years of hearings in communities. And I think that is roughly what you are saying. You are saying that most States are going to have to do that before they get into it or they will not save any money, or they certainly will not save it up——

Ms. MCCALL. They are going to have to develop an infrastructure. They are really going to need some technical assistance from the Federal Government, or from some other entity, to help them understand the kinds of things they are going to have to do to run a managed Medicaid program.

Arizona now understands that. There are lessons that Arizona has learned during its first development period which are very important for other States to understand.

The reason Arizona is successful now is because they have that infrastructure in place. They really have systems in place to collect data to be able to manage their competitive bidding process, to be able to look at quality assurance activities.

And I am afraid that not enough consideration is going to be given to that with respect to some of these other States who are jumping in from a fee-for-service program with not a lot of understanding about what needs to be done to make their programs run as good managed care programs.

So I guess my answer to your question is, it was not such a big success in the beginning, but we are 13 years into the program, and I think it is a big success now.

The CHAIRMAN. Now let me ask you this.

You are Ms. Checkett. You are running the system in Missouri, and you are the chair of the National Medicaid Directors. And the Congress passes a block grant, and we say to Missouri, you only get a 7 percent increase next year, not 10 percent. And after the third year, you are only going to get 4 percent.

Would your natural inclination be to say, I had better take a look at Arizona and see how they have done this, and see what I can learn?

Ms. CHECKETT. In Missouri and, as Dr. Vladeck said, 48 other States, there is already a great deal of managed care going on.

Since I am already looking at what you are talking about, my inclination is yes, we need to expand managed care, and I think States will do that. I do not believe that, under the time line that I am hearing, you are considering that States can reasonably look at managed care as a solution in anything in such a short time. It really takes a minimum of 12 to 24 months to develop the infrastructure that Ms. McCall discussed.

The CHAIRMAN. And I take it that some States are much further along on already developing it than other States?

Ms. CHECKETT. Right.

The CHAIRMAN. If the figures on Mississippi were correct, they have 200 to 300 people in home or community-based care, and all the rest of them in nursing homes, they are clearly a long way from getting into the shift.

Ms. CHECKETT. Absolutely. And I think States have very good experience on managed care with the AFDC population. You have seen the numbers, that it is not where the money is. There is very little experience with managed care for the seniors and disabled, and that is where the money is. And I certainly think the most significant issues, in terms of quality assurance, access, people who are disabled, many are mentally retarded, mentally ill, they have literacy challenges. So managed care is not by any means a silver bullet for dealing with funding reduction.

The CHAIRMAN. Let me ask Dick Ladd a question.

As Dr. Scanlon said, the number of nursing homes are actually down in Oregon. When we started to make the shift in Oregon from nursing homes to home and community-based care, what kind of problems did you run into with the nursing homes, or with the legislature, with objections?

Mr. LADD. There was major objection, Senator Packwood, from the nursing home industry. It occurred in 1982 and, if you recall, we had a special session in February of 1982, when people around the country quit building houses, and we were totally dependent on the lumber industry and fisheries in those days.

And we had to cut programs. So I called the nursing home industry in and told them they had their choice. I was either going to implement the system that would divert people from nursing homes to the community, or I was going to cut their budget by 10 percent.

They chose to do the implementation and did not fight us for 3 years. But, after a 3-year period of time, when they suddenly realized that their business—especially the private business—was going to community programs, they tried to get our waivers cancelled.

The CHAIRMAN. By private, you mean the non-Medicaid nursing home business?

Mr. LADD. Yes. Yes. Today, if you look at assisted living and adult foster homes in Oregon, what you see is that Medicaid only accounts for about a quarter of the people that live there. Private patients use most of those services out there. So they are really voting with their feet.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. We keep learning more and probably understanding less. I must thank Mr. Ladd for thinking of the nursing home business and the meeting in the Lieutenant Governor's office. When we set up programs, we create economic interest, and they become very powerful very quickly.

Soon, we are going to debate the issue of welfare. On our side of the aisle, we would create a new entitlement for guaranteed child care. And I would guarantee that, if enacted, there would soon be something called the "child care business." And there would be money in it. The next thing you know, the Lieutenant

Governor's office in Albany would be having meetings about the subject.

I have sat on this Committee for 19 years now, and I have never heard anything nice said about New York until you, Mr. Ladd. [Laughter.]

You said Oregon and New York are well advanced in long-term care?

Mr. LADD. Yes, Senator Moynihan. New York spends more per capita than any other State, and that could be good or bad, depending on how you look at it. But they have devoted enormous amounts of money to home and community-based care programs.

Senator MOYNIHAN. Well, could anybody explain, Ms. McCall, these depressing numbers? New York spent the most, $2,719 per person, and you spent $348. We have spent about 9 times more. Are we 9 times better than Arizona? Or is it just the weather?

Ms. MCCALL. I do not know. I have not studied New York.

Senator MOYNIHAN. A very thoughtful response. [Laughter.]

Ms. MCCALL. That is a researcher's response.

It is hard for me to address that. I understand that New York has a very extensive program, but the program is also comprehensive in Arizona. In Arizona the State determines eligibility for the long-term care program. They use their own pre-admission screening instrument, to determine who is at risk of institutionalization.

Senator MOYNIHAN. Well, it is not an equal number. You have 450,000 people.

Ms. MCCALL. Right. We have 450,000 people in the whole ACCHS program, but only 20,000 are in the long-term care part of the program.

Again, since I have not studied New York, I cannot be sure, but it could be that the State managing the pre-admission screening process is one factor.

Senator MOYNIHAN. One factor.

Is there any member of this panel who thinks we should go to a block grant for Medicaid, a flat block grant?

The CHAIRMAN. Speak up now. [Laughter.]

Ms. MCCALL. I may have to ask for a definition. By flat block grant, you mean——

Senator MOYNIHAN. You know what we are talking about here.

Ms. MCCALL. Well, you are talking about a lot of variations on a flat block grant.

The CHAIRMAN. Well, if Senator Moynihan means it in the ultimate sense, we say to Arizona here is your $150 million. Use it for health care for the poor.

Senator GRAHAM. But also, if I could add to that, we are saying, you get the same $150 million this year, next year, and the year after that, up to the year 2000.

The CHAIRMAN. That is true of welfare, but it is not true of Medicaid.

Senator MOYNIHAN. Well, Medicaid will follow welfare, I will bet you.

Senator MOSELEY-BRAUN. Mr. Chairman, I really like Senator Moynihan's question. Could we get a show of hands on that? Presume flat block grant, no strings, just the money.

Senator MOYNIHAN. I think poor Ms. McCall is going through a lot of agony. [Laughter.]

But I observe there are no hands raised. I appreciate that, sir.

The CHAIRMAN. Is that sort of like the "ayes" appear to have it, the ayes have it?

Senator MOYNIHAN. No, the "nays."

Mr. LADD. It is really a complicated question. In Oregon they had the 1915(d) waiver, which was a per capita cap, that you in this Committee passed in 1987. We were the only State to do that, and they had it up until 1993, when they gave it back. They finally went over the cap.

And that was a very generous per capita cap. That was set at the age 65-plus population.

Senator MOYNIHAN. And the Federal match continued.

Mr. LADD. Well, the Federal match was capped for long-term care.

Senator MOYNIHAN. But there was a Federal match?

Mr. LADD. Yes.

Senator MOYNIHAN. And the Federal Government did not limit it to a fixed total amount.

Mr. LADD. No. The big reason that they went over was the Boren amendment on nursing home reimbursement.

Senator MOYNIHAN. We have heard about that issue.

Mr. LADD. It made Oregon spend too much money in nursing homes. Otherwise, they would still be under that per capita cap.

So, if you are going to do a cap of any kind——

Senator MOYNIHAN. Thank you very much, Mr. Ladd.

Thank you, Mr. Chairman. Thank you all.

The CHAIRMAN. Do you not want to pursue your questions?

Senator GRAHAM?

Senator GRAHAM. Thank you, Mr. Chairman.

I am interested in the issue of transitional considerations, should we go to some form of a block grant.

Ms. Checkett, I think you recommended that it would take in the range of 12 to 24 months for States to be in a position to implement a managed care program which would begin to generate some of the efficiencies upon which these reductions are predicated. Is that correct?

Ms. CHECKETT. From the very beginning, if you had no managed care program in place, it would take you 12 to 24 months.

Senator GRAHAM. The proposal is to have this program commence as of October 1 of this year. That is, States would receive block grants presumably predicated on their historic amounts of Federal reimbursement, with some factor for a cost-of-living increase, which I think in the budget resolution is approximately 7 percent plus for fiscal year 1996.

How do you think——

The CHAIRMAN. They presume it for 2 years at 7–7. Then it drops to 4–4.

Senator GRAHAM. Four. What would be the effect on States of that kind of a new structure, as of the first of October?

Ms. CHECKETT. It will vary tremendously, State to State. Some States, through a combination of extensive managed care or simple reductions in services and rates—Indiana being a good example—

are going to see their expenditures going down this year from last year.

And I believe some States will be able to live within the reductions. Others will not. Mine in particular—and I will speak now only for the State of Missouri—cannot. Our growth rate has been between 8 and 10 percent for the past 5 years. And the largest amount of our growth is with elderly and disabled, who live longer and longer and longer.

So managed care will not be our answer. It alone will not produce those types of savings. And I think ultimately—again speaking for Missouri—we will have to look at reducing eligibility, also known as putting people off the rolls.

Senator GRAHAM. So how many elderly people in Missouri are receiving Medicaid assistance?

Ms. CHECKETT. Ours is about 26 percent. I am thinking out loud. The numbers are about 18,000 people.

Senator GRAHAM. Eighteen thousand?

Ms. CHECKETT. My math is probably wrong. It would be 180,000 people.

Senator GRAHAM. One hundred eighty thousand people. Do you have any idea how many of those 180,000 elderly persons' eligibility might be jeopardized?

Ms. CHECKETT. I do not, because it is going to be the growth in the program, and we would have to look at whether we would lessen the amount of money you can have in order to be eligible, or the criteria for entering into a nursing home would have to be increased.

So I cannot answer that question, but I can tell you that in Missouri, we think that by about the third year we would have to look at reducing eligibility. It is the only way to get the magnitude of the dollars. Managed care produces marginal savings. If we do not cover some optional programs, those are marginal savings.

The Boren amendment, other things, are all working around the edges. The fact is that it costs Missouri about $8,000 a year for a person over the age of 65. So it is very hard to get significant savings, other than by just saying you are not eligible.

Senator GRAHAM. I wanted to raise a couple of other transitional issues, if I could.

Second was the question of the relationship of Medicaid and Medicare. If Medicaid, with its State participation, is required to continue to pick up some of the Medicare cost for the indigent elderly, such as the Part B premiums, the copayments, the deductibles, and so forth, what would be the effect of that on the flexibility of States to use their now block granted Medicaid funds?

Ms. CHECKETT. Well, we obviously will dip into that reservoir of funds if we have to continue to pick up the premiums and copayments for individuals who are coming onto Federal Medicare programs. That is one of our recommendations, that you take that portion of the program back.

Senator GRAHAM. Do you have an idea of how much of your Medicaid expenditures in Missouri are spent to pick up Medicare costs, such as those I listed?

Ms. CHECKETT. I am sorry, Senator, not at this time. I believe that the national expenditures for the qualified Medicare beneficiary and the select Medicare beneficiary—the SLMB's as we call them—is about $4 billion right now, for the nation, just for those QMB's and SLMB's.

Senator GRAHAM. A third area of transition was mentioned by Ms. McCall. That is the need to assist the States in developing their infrastructure and administrative capacity to handle these new responsibilities.

What is your assessment of the state of the States' capacity to assume this, and what would be entailed to elevate that capacity to a level that you would feel, as a matter of public administration, to make them capable of carrying out these programs?

Ms. MCCALL. Well, I think that is a very good question, Senator, and it is a difficult question to answer.

I think that it would require an effort from somebody either at the Federal level, or some other mechanism, to help them understand some of the issues that are part of a managed care program.

Many of these States have run fee-for-service Medicaid programs for a long time. But the kinds of things you have to do to run a managed care program are really quite different. You need to collect encounter data, which is a different kind of thing than collecting bills and processing them.

You need to figure out a way to procure providers, and decide how you are going to pay them, and who you are going to accept as providers. And you have to have standards set up for procuring providers.

You need to enroll people and let the plans know who is enrolled right away, so that they know who they are supposed to be providing services for. The administrative parts of doing that are complicated.

I have not really worked with any States directly, but my impression, from talking to a number of States, is that many of them do not understand all the things that need to be done, nor do they have the technical resources available to them to be able to do them. Most of these things require computer skills, and individuals who have technical expertise. Attention to this by the Federal Government would be helpful.

Another important thing is just helping States to understand why they need to collect the data. If they go into a system where they are going to capitate beneficiaries, and they do not have information on utilization of services, they are going to be at a very big disadvantage down the road to be able to continue to do that.

And the same with quality assurance. They will not have complete data to do that.

So I am afraid some of the States, given complete flexibility, are not going to give attention to these kinds of things, and that they are inevitably not going to be very unsuccessful in being able to put together a managed care program, a program which has tremendous potential to save money.

So I think a lot of people, when they talk about flexibility, are really talking about design, reimbursement and coverage issues. And I think it may be very appropriate to give States flexibility in these areas.

But I hope that we continue to worry a little bit about this whole infrastructure development issue, because having appropriate infrastructure gives an opportunity to be successful.

The CHAIRMAN. Senator Moseley-Braun?

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman.

And that is precisely where I would like to pick up, because I think there is real cause for concern that we do not wind up with a Tower of Babel syndrome developing among the 50 States with each State collecting its own data, based on whatever, and putting it together in different ways. And we lose the capacity to have any kind of uniform data, any way of tracking where the Federal dollars are going, and the like. So I think the Tower of Babel is something I think we need to be careful about.

In your earlier testimony, you started to talk about four areas. You mentioned four areas in which there should be uniform data collection. And the Chairman mentioned consumer interests and consumer satisfaction in another context.

I would ask you, would you go over those four areas, and are there any other members of the panel who have suggestions that we have uniform data collection in areas beyond the four you mentioned in your earlier testimony?

Ms. MCCALL. I would be glad to. The first thing was standardized reporting of utilization, or encounter data, and of program costs.

The second was technical assistance in issues of program implementation, which is a big topic, and we would include a number of things. The two that I pointed out were the development of administrative infrastructure and quality assurance. But I certainly think that a grievance process and a process for reassuring beneficiaries satisfaction is also appropriately part of that.

Coordinating and funding studies to try to figure out what works and what does not. And then, providing a forum for sharing of information. I think that is critically important.

I also think it is important to give the States an opportunity to be part of the process of developing these things.

Senator MOSELEY-BRAUN. Oh, absolutely.

Ms. MCCALL. Not just to say that these are the standards that are going to be used for reporting utilization data, but to give States some input into that process, so they feel brought into the fact that this is important.

Senator MOSELEY-BRAUN. I think there is no question about that. And the idea of giving the States the flexibility needed to innovate is part of the whole purpose of this exercise. The question is whether or not, at the same time we allow flexibility, we do not have a Tower of Babel with different States saying different things, and not being able to communicate one State to another, or to share successes.

If you are going to make the States laboratories then, at a minimum, they ought to be able to communicate with each other what comes out.

Yes, Dr. Hurley?

Dr. HURLEY. I would certainly echo that concern. And I would like to kind to amplify on something I said earlier. This program in Arizona has taken 12 to 15 years to mature. For the first 5 years, there probably were not the data that Nelda just made reference to. And I think it brings home the point that infrastructure at the beginning of a program is an essential piece of this.

And if we think about block grants, or any accelerated implementation that involves shifting financial risk to the States, my principal concern is that the immediate reaction of the States will be to shift financial risk to any managed care plan to whom they can write a capitation check.

And I think that to do that, and to do that in kind of a high pressured environment and situation, really does invite the kinds of abuses we have heard this morning about marketing and rapid enrollment in plans that are not fully matured.

So I think that therein lies the risk of doing this in a deliberate and meaningful fashion. It mitigates against doing it too rapidly, that the system cannot support the kind of program that you would like to be comfortable with.

Senator MOSELEY-BRAUN. Dr. Scanlon?

Dr. SCANLON. I would agree with everything that has been said. I think though that we have to recognize the fact that we are, in some sense, always going to remain in an evolutionary situation.

We are at the point now where we are starting to focus on outcomes, and we have high hopes for what we are going to be able to do in terms of monitoring the outcomes of the health care system. But we are at the beginning of that endeavor.

Talking about the Arizona system as being mature is accurate in one respect, but they continue to evolve. Oregon is the same situation. Even though they had a longer period of time devoted to design and planning before they implemented their 1115 waiver than virtually any State, they continue to review and adjust their program.

I think we have to recognize that we will always be in a position where it is important to remain vigilant, to understand what we are buying with our health care dollars, and to be assured that we are satisfied with the efficient use of those health care dollars.

Senator MOSELEY-BRAUN. I would like to kind of shift a little bit—well, actually, this is not much of a shift—and talk about the States' experiences in terms of long-term care, and whether or not there is comparative data regarding the States' experiences with a blend or mix of nursing home versus community-based and in-home care. Has there been data collection regarding the relative costs, the quality of care issues across the States in this regard?

Mr. LADD. We just finished a study. It is not published yet, but we will be publishing it at the end of the year with the University of Minnesota. This study compares States around 1992 in 39 different statistics. And we will probably update that as soon as we get the 1994 data, to bring it up to 1994.

So it is a compilation of things that already exist. But there have been numerous studies about quality of home care and nursing homes. Probably the biggest study was the channeling projects that were run in the early 1980's.

Senator MOSELEY-BRAUN. In brief, could you summarize what those studies tell us?

Mr. LADD. Well, the channeling projects told us a number of different things. I was in a meeting in New York City on Monday where we talked extensively about some of the results. And I even heard things that I did not realize that the channeling studies contained, or I forgot.

Mainly, they told us that people prefer home care, although it may not be any cheaper. It depends on how you do it.

Those studies have been going on for 20 years and, to be quite candid, they are on both sides of an issue, whether it is more expensive or not.

Dr. SCANLON. Let me add something to that. I think we have learned a lot about home care, and about how it is much preferred by the recipients and their families.

I think, though, as we look across the country, we see tremendous variation in both the quantity of nursing home care and the quantity of home care that are being received. And we do not have a good sense of what that variation means for the population that is in need in any State.

States start from very different points, and adjust their programs over time, but they still remain very far apart. And I think understanding that variation is a question we really need to address.

Senator MOSELEY-BRAUN. Well, that is my question, if the study had been with regard to those variations, if we had any data, any information that was documented regarding the different experiences in the various States?

Dr. SCANLON. Not in the depth that we really need.

Senator MOSELEY-BRAUN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Ms. Checkett, I just want to know what this means in your statement. "States appreciate the efforts by HCFA to improve these processes, but the waiver application, approval and renewal process is still time-consuming and costly. APWA recommends that the Federal requirements that necessitate waivers be eliminated." What does that mean?

Ms. CHECKETT. What waiver requirements we would like eliminated or——

The CHAIRMAN. No. It looks to me like you do not want to have to apply for any waivers.

Ms. CHECKETT. We do not want to have to apply for waivers.

The CHAIRMAN. You would like to be able to do what you like?

Ms. CHECKETT. Yes.

The CHAIRMAN. Is that not a block grant?

Ms. CHECKETT. Oh, I do not know enough about it. I guess I cannot answer that question.

Senator MOYNIHAN. I think he got you there. [Laughter.]

Ms. CHECKETT. Am I trying to say that? Well, a block grant, of course, would say that you are limiting the amount of money that a State could get, along with giving us flexibility.

I would say that I would like to have all the money I get right now, and be able to do everything without a waiver.

The CHAIRMAN. Ah, now we come to it.

Ms. CHECKETT. States always want everything, right?

The CHAIRMAN. Well, everybody wants everything. It is a Peter and Paul argument, no matter where you see it.

So you are not adverse to the States having rather broad discretion to do what they want without having to apply to HCFA for waivers all the time?

Ms. CHECKETT. No, by no means.

The CHAIRMAN. So the only thing we really are debating is the amount of money?

Ms. CHECKETT. Well, I would not say that is the only thing we are debating, but——

The CHAIRMAN. Well, if you have broad discretion to do whatever you want——

Ms. CHECKETT. Oh, you gave me that part already?

The CHAIRMAN. I will concede you that. Then are we really talking about money?

Ms. CHECKETT. Oh, it would be too simple to say that the only thing we are talking about is money. There is obviously——

The CHAIRMAN. Is it the big thing we are talking about?

Ms. CHECKETT. That is the big thing, sure.

The CHAIRMAN. And then there are some other little teensy-bitsy things. But, if you can do what you want, you can put the little bitsy things on the block grant?

Ms. CHECKETT. I am sorry. We can put it all under the block grant?

The CHAIRMAN. Well, I am trying to figure. I know where you want to end up. I understand this.

Ms. CHECKETT. Sure.

The CHAIRMAN. You would like to have as much discretion as possible to administer your program in Missouri as you think best, without having to apply to HCFA all the time to say I think we can do it better in Jefferson City this way. You would like that?

Ms. CHECKETT. Sure.

The CHAIRMAN. That is the philosophy of a block grant. And I understand that you are talking about money. And it is not only the total money, it is the formula. Who gets how much money out of the fixed amount of money that you have?

But what are the little things that you could live with, in terms of attaching it to a Federal grant, that would still give you all of this discretion so you do not have to have waivers? What are the things that do not bother you, that would be attached to the Federal grant?

Ms. CHECKETT. I am sorry. I really want to answer your question. The things that do not bother me?

The CHAIRMAN. Well, you would like broad discretion.

Ms. CHECKETT. Right.

The CHAIRMAN. That is sort of the philosophy of a block grant.

Ms. CHECKETT. I know.

The CHAIRMAN. It is the old revenue sharing. That was the ultimate block grant—here is your money, use it for anything you want. And some States used it wisely, and they realized that 1 day it might get cut off, so they used it for capital expenditures. Others started building it into their budgets. So, once it got cut off, they were in desperate shape because they had been counting on it year after year.

But, assume we were to go to a block grant, forgetting for the moment whether you get as much money as you want—you will not.

Ms. CHECKETT. I know that.

The CHAIRMAN. All right. And we are going to say all right, from now on, you will not apply for these waivers. I am trying to figure this out. You have gotten out from under the waivers, you can do what you want, you have not got as much money as you want, although you have more than you are getting now.

I am trying to figure where the middle ground is, the hesitance you have about that kind of system that caused you not to raise your hand when Senator Moynihan asked who wants block grants?

Ms. CHECKETT. Again, speaking for the State of Missouri, I think a lot of the savings that will come from that flexibility will be marginal savings.

When we look at our State's expenditures, we have grown 8 to 10 percent over the past 10 years, and we lay that across the expenditures off our base line, at the end of 7 years we will have over $1.2 billion less. And the only way that we can——

The CHAIRMAN. But this is a money argument.

Ms. CHECKETT. I understand that. But what it will mean when we translate that into our program is that we will have to tell some people that we are sorry but we do not have enough money to cover you.

And we have a lot of concern because the problem in Missouri, which is growing, is that those are the people it is very hard to say no to. There are people who need nursing home care. There are people who are disabled. They are not able to hold a job. The single most important thing to both of those populations is their health care. It would be very tough to say no.

The CHAIRMAN. Those are tough choices that we make, that you make, that every State makes.

Let me phrase the question in another way then. What if the alternative is that we attempt to meet our budget totals of 7 percent increase, 7 percent increase, and then 4 percent, 4 percent, 4 percent, and we do not give you any discretionary authority? So we have reduced the increase in the growth of money. You still have your same money problems, and you have all of the strings and the waiver applications that still go with the current law.

Ms. CHECKETT. My greatest fear.

The CHAIRMAN. I think that is a good place to stop my questions. Senator MOYNIHAN?

Senator MOYNIHAN. Well, I will pick up, if I can.

Did I hear you say, Ms. Checkett, that you look at the curve, the projection of your Medicaid costs, and then you lay against it the 7, 7, 4, 4, 4, and you come out $1.2 billion short of what you would project you would otherwise be spending?

Ms. CHECKETT. Yes.

Senator MOYNIHAN. Well, it would serve you right for having a Republican Governor. [Laughter.]

Ms. CHECKETT. I have a Democratic Governor. Mel Carnahan is a Democrat.

Senator MOYNIHAN. God, that is right. Serves me right for making smart remarks.

Ms. CHECKETT. I have worked with Governor Bond's and Governor Ashcroft's administrations, so I have been all around.

Senator MOYNIHAN. Look out, it is coming your way.

Ms. CHECKETT. I know that.

Senator MOYNIHAN. And I do not know that we have any sense of this huge experiment. I am just as apprehensive as one can be, but that is the way it is going.

Ms. CHECKETT. If I could perhaps respond to Senator Packwood's issue, at most I would say that I look at it as, if then, the greater the reduction, the more flexibility we have to have.

I do think that in Missouri, and in a fair number of States, we are going to wind up having to make very tough decisions.

The CHAIRMAN. The greater the reduction, the more flexibility you need?

Ms. CHECKETT. Right. To make some very tough decisions that we will not want to make, like——

The CHAIRMAN. But if the reduction is greater, you would rather have the authority yourself to make them, rather than to shuck that off to us and we sort of force them on you?

Ms. CHECKETT. Right.

Senator MOYNIHAN. Can I say, Mr. Chairman, the budget resolution is not clear, is it, that they propose a block grant, period?

The CHAIRMAN. No, it is not clear. All this Committee has are instructions to save $530 billion out of the $620 billion entitlement saving, and we can do it in any mix we want—out of Medicare, Medicaid, the earned income tax credit, welfare or SSI.

But, to the extent we get into this fight on welfare, it is just an itsy-bitsy battle in comparison to Medicaid. If we try to hold every State harmless, and give the growth States money, that costs some money. And that means, if we are going to hit our totals, what we spend on the formula we have to pick up someplace else.

Senator MOYNIHAN. When we first put Medicaid in place, it was done as a supplement for AFDC. Long-term care, incidentally, developed out of this. The nursing home industry came along. I would hope that there would be some harmony between those two formulas. But maybe there cannot be.

But the war between the States has resumed, as you probably know. With any luck, it will be a protracted conflict that will go on for another 4 years at least. [Laughter.]

Thank you, Mr. Chairman, very much. I thank this wonderful panel.

The CHAIRMAN. Senator Graham?

Senator GRAHAM. Mr. Chairman, I am going to defer to Senator Moseley-Braun first, but I would like to ask some questions.

Senator MOSELEY-BRAUN. Thank you very much. And thank you, Senator Graham for your consideration. I will be fairly brief.

I want to take this string, and kind of start it with Senator Moynihan's questioning of Ms. Checkett. I would ask the panel to take it one step further, because I think we have to be mindful of the universe in which we are negotiating here.

Ms. Checkett, you mentioned that some of the States, given fewer dollars, flexibility notwithstanding, would have to reduce eligibility and change eligibility rules and requirements. This will mean, as you say in the old language, putting people off the rolls.

Therefore, my question is, assuming that some of the States—and particularly the heavily impacted States—that already start off behind because of the formula issues in terms of the dollars they need to work with, what happens then? Then what? When you put people off the rolls, then what?

In this country, nobody goes without health care. Everybody gets cared for in one way or another. At least that has been the American tradition, that everybody gets cared for.

Assuming for a moment that they have now been put off the rolls of Medicaid, which was always considered to be the safety net for the disabled, for the indigent elderly and the like, who is going to pick those costs up? Who is going to pay for that care?

A hospital in a rural community or an inner city is going to see a sick baby sitting on the front steps. It is not going to just leave that child out there because the State or the Federal Government is not going to pay for it. Who then is going to pay for that child's care?

You are the experts. This is a great panel. Come on, let us hear it.

Dr. HURLEY. Well, I think I already spoke to that issue. I would like to return to it. I think what is happening with managed care right now is that it is suppressing the ability of hospitals and other providers to cost-shift, as they have historically done, because they are being paid less by the managed care plans.

That certainly compromises their ability to have money available to serve the uninsured. And I think the scenario you describe is going to be played out in many urban areas in the not-too-distant future. Because, even as Medicaid programs succeed in curbing their rate of increase by enrolling more of their beneficiaries into managed care plans, they too are contributing to the shrinkage in the capacity of the safety net providers to serve other populations.

So, if we increase the number of people shifted from Medicaid to the uninsured, then the problem is exacerbated.

Mr. LADD. The States have run into budget problems at one time or another on their own, and had to make reductions on their own. Every State has been through that. In the 15 years that I have managed programs at the State level, we have been through it four or five times.

It is rare that States with the aged, blind and disabled populations cut people out of service. But, when it does happen, you try to make sure that those who least need that service are first cut. And States do that primarily with assessment instruments, and let them know who least needs that service.

From then on, what you may do is set up waiting lists for services, if you do not have enough money to get new clients. And then you do not replace people who die or leave care in that interim period, until your resources are down to the point you can start expanding again.

Ms. CHECKETT. I think that the hospitals will step in for these acute situations, as they do now. And there is a major concern about what will happen with public hospitals who are being impacted, as Dr. Hurley addressed, by managed care. And it is a true issue.

But the care that is not provided now to indigents in States where the number of indigents grow because of Medicaid reductions, the services that will not be provided are physician care, primary care and access to pharmaceutical services. And it is a tremendous challenge. And you will have people with chronic conditions simply not taking the medicine they need to control those conditions.

They exist now. We have many in our country right now. So I just look at that as increasing. Then when people are sick enough that they need hospitalization, hospitals in general do step in. There are very few children born on steps of hospitals. It just does not happen.

Senator MOSELEY-BRAUN. Right.

Ms. CHECKETT. But the early stages of treatment and intervention, or beginning illnesses, that is what will not get touched.

Senator MOSELEY-BRAUN. Are the States at all concerned that they may be looking at tax hikes at the State and local level to address these issues?

Ms. CHECKETT. Yes.

Senator MOSELEY-BRAUN. There is some concern about that, and there has been discussion?

Ms. CHECKETT. Yes.

Senator MOSELEY-BRAUN. So we are essentially devolving costs as well?

Ms. CHECKETT. There is an awareness that States will have to make their own decisions about how to deal with this. There will be an increase in the indigent costs for certain services.

Some States will choose to increase taxes, or the local governments will. Some States will simply choose not to do anything, just allow those costs to be there.

Senator MOSELEY-BRAUN. Thank you very much.

Thank you very much, Senator Graham.

The CHAIRMAN. Senator Graham?

Senator GRAHAM. Thank you, Mr. Chairman.

Mr. Chairman, I share the feeling of what a helpful panel this has been. If I could make a few comments and observations on what we have heard today, it seems to me that we have been given a belief that is almost Biblical in nature, that the only way in which to achieve the goals of cost reduction is through increasing State flexibility.

And the only means of achieving State flexibility is through a block grant, and that we should be prepared to accept the rigidities and the withdrawal of the stability which a Federal individual guaranteed program has brought over the last 30 years to our efforts to provide health financing to low-income Americans.

Some of those stabilities that are at risk here are the stability against economic changes, particularly when it affects one State or one region of the country. In the last 10 years, we have been through a rolling set of economic recessions, which started in the mid-West, moved to New England, and then moved to California, with other areas being touched from time to time during that period.

Because of the individual guaranteed nature of Medicaid, as populations shifted in need because of economic circumstances within their State, the Federal Government provided a stability that was able to respond when people move.

Ms. Checkett talked about Missouri having annual increases in recent years of 8 to 10 percent. My State of Florida has had average increases within the range of 13 to 15 percent. The reason is almost totally a reflection of the demographic shifts that are occurring within the country. So we will face the prospect of losing that stability to relate to changes in where Americans choose to live.

Now the questions is, do we have to give up those stabilizing factors in order to achieve our goal of greater flexibility and, hopefully, through that, somewhat greater costs. I think not. I believe that what we have been doing is operating, rather than in a surgical clinic where we operate with precision, we have been in the butcher shop with a big ax, hacking away.

Dr. Vladeck has indicated that there a number of statutory and policy areas which restrain the ability of a fully flexible waiver system, or even moving beyond a waiver system to a substantially less restrained relationship between the Federal Government and the States in how they would administer, but still maintain, an individual guaranteed program.

I think we ought to look seriously at that list which Dr. Vladeck is going to bring back to us, and see which of those ought to be pruned away.

I think we also need to have a much more bottoms-up look at the economics of this situation. These numbers of 7 percent for 2 years and then 4 percent thereafter, are very arbitrary.

As Ms. Checkett has indicated, it is going to take a year or two for most States to get to the point that they can even achieve the relatively marginal benefits which she thinks will come with that flexibility. Yet we are talking about starting the program in a matter of less than 90 days.

I think that we also need to be honest with ourselves. If what we are really doing here is saying we are using the fig leaf of block grants to create the second fig leaf of greater savings through flexibility, but the actual result is going to be that either people are going to be denied access, as some of those 180,000 elderly in Missouri, or we are going to be shifting costs back to the States, or the States shifting costs back local governments and private health care provider.

That is what the whole objective of this operation is. Let us face what our goal is, and what the consequences are going to be, and see if that is the kind of policy that we wish to adopt.

But I reject this idea that there is some degree of almost predestination, that we have to take all of these steps in order to achieve this goal. Your comments today have helped to underscore that.

Now, with that long introductory statement, I would like to turn to a specific issue. That is, one of the things that is most encouraging about what has happened in recent years has been the degree of innovation that has been allowed at the State level, so that we have the example of an Arizona, and what it has accomplished, and the model it is providing to other States.

The work in Oregon and Hawaii and Maryland, and other States that have had some form of waivers, has been equally constructive in terms of developing a national understanding of the realities of these issues.

What do you think should happen to those waiver States if we were to go to a block grant program or to the program that the administration is proposing, which is a capped, per capita program? Should we say to those States, we appreciate your contribution, but we cannot continue to meet the understanding with which you entered this program? Or should there be some continuation, or some third path of a transition?

Ms. McCall. Well, I think you probably need to think about it on a State-by-State basis.

Some of the things that Bill said suggested that some of the States appear to be in a better position to move ahead than others do. I think you need to look at each State and ask what is going to be the impact?

We have already made a commitment to these States to give them waivers, or the Federal Government has, and we need to look at those States and ask how this fits into what is going to become a new strategy, and decide based on that.

I do not know what your abilities are to take back waivers, and that needs to be considered.

Dr. Scanlon. I think there are two very distinct aspects to the waiver. The first involves the State's ability to innovate. The waivers have been used to allow Medicaid to enter into the mainstream. We have 1915(b) waivers in a majority of the States to allow managed care. We have recently had 1115 waivers in certain States to use managed care more aggressively. Managed care has almost become the norm for our health care delivery system. Therefore, one would expect that the authority to continue to utilize managed care would continue.

The case of home and community-based services is similar. There have been strong preferences indicated by the persons needing long-term care that these are the kinds of services they want. And States have found cost-effective ways of delivering them. So one would expect their provision would continue.

The other aspect is the issue that we raised about using Medicaid to cover some of the formerly uninsured. This is a new activity that has occurred through waivers in the last 2 years, and it is something that the Congress has not really been actively involved in or explicitly approved.

How to deal with this aspect would be a question that the Congress would have to face. What should happen to those persons who are brought into the program, who would not normally be eligible for the program? Do you want to continue coverage permanently, or during a transition period, or are you going to terminate it more quickly?

Ms. Checkett. The Medicaid Directors' Association does have some specific recommendations on this, not surprisingly. And we do believe that the States who have worked long and hard for those 1115 waivers—and there are 10 that are approved—have a contract with the Federal Government, and should be allowed to continue that.

It does mean for those States that some of them would have higher growth rates than are now in the budget resolution. And our recommendation is that that funding come from additional Federal funds, not from the current pool. In other words, we would not recommend taking from one State to fund an 1115 waiver State. But we do think they should be allowed to continue those programs, if they choose.

Mr. LADD. I was going to say that it is a two-edged sword, Senator. Using two examples, I finished a study of the State of Texas nursing homes in February, in which I found that 27 percent of nursing home residents in Texas had no functional disabilities and very little medical needs. One would have to ask, why were they there in the first place? Texas spends half a billion dollars in Medicaid funds to support them each year.

And that is an area which, obviously, can be reduced. Other forms of living situations could be found for those people that would cost a lot less than what Texas is paying for right now. The issue was ignored in the session that just finished, and they are still in those nursing homes.

On the other hand, Medicaid today pays for about 40 percent of live births in the United States. And we know that infant mortality has gone down, and continues to drop. So, when States have flexibility, a lot of States do not like the idea that they are paying for all those live births. Some States will get out of that. And I am fearful that what you will see is a rise in the infant mortality rate, back to the levels it was previously to Medicaid paying for that.

Senator GRAHAM. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Pat. I always marvel at the luck we have in the caliber of the witnesses we get. You have been wonderful this morning. Thank you very much.

Senator MOYNIHAN. Thank you.

[Whereupon, the hearing was recessed until 9:30 a.m. Thursday, July 13, 1995.]

MEDICAID: INTEREST GROUPS' PERSPECTIVES

THURSDAY, JULY 13, 1995

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to recess, at 9:30 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman of the committee) presiding.

Also present: Senators Chafee, Grassley, Simpson, Pressler, Moynihan, Bradley, Rockefeller, and Graham.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order, please. This is the fourth in a series of hearings on Medicaid. The groups testifying this morning represent mainly beneficiary groups, or recipient groups.

As you are well aware, we have been ordered by the Budget Resolution to attempt to save $182 billion in Medicaid over 7 years and, to the extent you can give us some advice or help in that direction as to what would be the fairest way to go, it would be very helpful to us.

We have to meet that total. I understand everybody would like us to meet the total someplace other than out of their particular group, but one way or another we have got to meet it. So, if you have comments on that it would be helpful.

We will start this morning with Sheldon Goldberg, who is the president of the American Association of Homes and Services for the Aging.

Mr. Goldberg?

STATEMENT OF SHELDON L. GOLDBERG, PRESIDENT, AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING, WASHINGTON, DC

Mr. GOLDBERG. Mr. Chairman, members of the committee, my name is Sheldon Goldberg. I am the president of the American Association of Homes and Services for the Aging. I tremendously appreciate this opportunity to testify before you and this committee to share our hopes, our concerns, and our significant fears about the future of Medicaid in this country.

We represent non-profit facilities. We have 5,000 members across this country; some going back to Revolutionary War times have consistently served people in this country. We have nursing homes, retirement homes, continuing care retirement communities, senior centers, and a broad range of other community-based services. Our members serve, at this moment across America, over a million people.

I will not tell you what you know already and what we understand and that is that you are struggling with the decisions which you will have to make in the very near future. We are at a very critical juncture and the decisions to be made in the next few months will impact upon health care and the well-being of our Nation's elderly now and well into the future.

Medicaid is a policy and a promise. It is a promise to those who do not have the economic resources in this country, that someone will provide those health care benefits.

It is a policy and a promise because those who reside in long-term care facilities, mostly the elderly, are people who have worked hard for our society and contributed to our society for many, many years. They have outlived their savings and simply by growing old they exhausted the resources available to them.

We have great fear. We have great fear about what is going on and what potentially could happen to Medicaid, especially with the concept of a capped block grant. And with little or no Federal oversight, as we have seen in some of the proposals coming out of the House of Representatives, we are fearful for the beneficiaries, for people who have worked hard all of their lives, who all of a sudden will be relegated into second, perhaps even third, class citizens.

But, Senator, we also appreciate the dilemma facing you, and that dilemma is, how do we deal with the Federal deficits, which are real, and the second is, how do we begin to cut the cost of care?

Briefly, let me share a couple of my thoughts. Number one, half the people in nursing homes in America, approximately, are funded by the Medicaid program. There is very little private insurance that goes into nursing homes and this type of care. The fastest-growing part of the elderly population in this country is over the age of 85, the people most at risk of going to a long-term care facility.

We are concerned that the block grant concept would signal the end of the Federal entitlement program that we know as Medicaid today in this country. We feel that this would cause great destruction and many kinds of problems.

If these funds are turned over to the States with little or no Federal oversight and control, we are fearful what will happen to the people without requirements that the States at least maintain their level of involvement in the Medicaid program as it is today.

Let me go back a couple of years—and I know this is an issue that you are very familiar with, Senator Packwood—when many States had to figure out how to meet their Medicaid match obligations. They provided what we call granny taxes. They taxed the most vulnerable, frail, elderly people in our society. In 26 States they created granny taxes.

The people who paid these taxes were private-pay residents in nursing homes, frail and vulnerable themselves. They had a tax burden added to them solely to come up with the State's match to meet the Medicaid program's requirements. That type of tax which still exists in many States across this country, will not work in the future.

We feel that there are major, major issues that need to be addressed before going to this concept of a capped Medicaid block grant program.

There are a whole series of other issues that we are very, very concerned about. How will it affect States when there are economic vicissitudes, changes in population, demographic changes such as are happening in Florida, and how do we balance this thing off to make sure they solve the problems within those States and they maintain their efforts to serve these people?

But perhaps our biggest concern is about quality, about what happens to the people. First of all, let me say my members are not-for-profit. They have gone into this field because they believe in a mission. They go back many, many years. That mission is serving people.

I will tell you candidly, our members lose between $10 to 15 every day for every Medicaid resident, on average, across this country. We are not making it right now. That is not unique to non-profit homes.

We did an analysis of the 16 largest publicly-traded nursing home corporations in America and we found their margins are almost zero as well in providing nursing home care, and it is zero when it comes to Medicaid. They make their money in other ventures, by providing ancillary services, by moving into subacute care, by doing a host of other things, or concentrating on private pay residents. That is the only way they can make it in this kind of system, and those are the issues with which we are concerned.

Seventy percent of a nursing home's expenses are wage payments, primarily for nurse aides. These are primarily low-paid individuals, who many times do not even have health insurance and other benefits, and these are the people who are working directly with our residents. It is very difficult to retain these people working in nursing homes today.

The Boren Amendment simply requires that States reimburse for costs incurred by efficiently and economically run facilities. Efficiently run facilities. To weaken that type of language or to take it completely away leaves us concerned about whether some kind of standards will be set or some kind of goals will be established.

Those are our principal concerns. But we also have to recognize, you have real budget limitations so let me touch on that very, very briefly.

Yes, there is waste, there is fraud, and there is abuse in the system. It has to be rooted out, it has to be dealt with, and it has to be dealt with aggressively.

There is a need for greater flexibility to the States. The State of Oregon has been probably the greatest champion of flexibility and doing things in a very creative way. We need to streamline the process for 1115 waivers and for 1119 waivers to let States experiment and try things that work, and in Oregon it is working very, very well.

We need to cover a broader range of services that can replace the higher costs that exist in a nursing home. Home and community-based services, housing programs that keep people out of nursing homes.

One of the things that we learned from the PACE program as the most important denominator is literally having appropriate housing for people. It forestalls the need to go into a nursing home or other long-term care arrangement. It may be critical for the future. We also need tax clarification and incentives for the purchase of long-term care insurance.

Mr. Chairman, let me close very briefly, in less than a moment, if I can. We appreciate your needs to cut spending. We know how sensitive this committee will be to that, and it is a very daunting task. But we also hope that you will give pause and serious consideration to the ramifications of cuts.

Let me close, if I can, with a refrain that I hear often from old persons as they talk across the country. It is a paraphrase of what I hear so many times as I visit our facilities. This is from a resident. "I am not afraid of dying, but I am afraid of growing old, of becoming sick and becoming dependent, of losing my family and friends, of losing my dignity as a human being and as a person."

Our members are committed to helping to maintain that dignity and I believe this Congress is devoted to helping them as well. So I ask you to also help us in our concerns about block grants, about moving away from the ability to provide reasonable, cost-effective care.

I very much thank you for your consideration and your sensitivity to this issue. Thank you very much, Senator.

The CHAIRMAN. Mr. Goldberg, thank you.

[The prepared statement of Mr. Goldberg appears in the appendix.]

The CHAIRMAN. Now we will take Gregg Haifley, who is the senior health associate for the Children's Defense Fund.

Mr. Haifley?

STATEMENT OF GREGG HAIFLEY, SENIOR HEALTH ASSOCIATE, CHILDREN'S DEFENSE FUND, WASHINGTON, DC, ON BEHALF OF THE MATERNAL AND CHILD HEALTH COALITION

Mr. HAIFLEY. Good morning, Mr. Chairman. I am Gregg Haifley, with the Children's Defense Fund, which is a member of the Maternal and Child Health Coalition, which thanks you for inviting us to testify today on the Medicaid health safety net that now covers one in four children in America, and one in three infants in this country.

We have a very simple message to convey today. As you consider reform of the Medicaid program, we believe it is essential to maintain the guaranteed Federal floor of eligibility, coverage of prenatal/prevention services, all other medically necessary services that are covered currently by the Medicaid program, and preserve the access provisions for appropriate care for children and pregnant women.

We have attached to our written testimony a set of recommendations that have been endorsed by over 150 organizations throughout the country that have maternal and child health as an agenda, as well as a statement by 13 national organizations which represent pediatric health care providers, all of which support the position that I am articulating today.

Because of the eligibility expansions of the 1980's and early 1990's, Medicaid has increasingly become an essential source of health care coverage for children and pregnant women in low-wage working families. Today, among all children covered by the Medicaid program, more than half live in working families. And of the 1.4 million infants covered by the Medicaid program, 70 percent of them are now from working families.

Medicaid has played, as you know, a crucial role in offsetting the long-term trend of declining health insurance coverage, private employment-based health insurance coverage, for dependents.

Without these Medicaid expansions, millions more children and pregnant women would not have been covered. Between 1977 and 1987, employer-based insurance for children declined from 72.8 percent to 62.9 percent, and that trend continues today with nearly 800,000 children a year losing coverage. Medicaid covers one in three births in America, and now nearly 17 million children.

In terms of services, I would like to emphasize that it is essential to maintain the existing coverage of benefits for pregnant women and children because of its critical furnishing of prenatal care, preventive care, and medically necessary care that I mentioned earlier.

The Early and Periodic Screening, Diagnosis and Treatment services, the benefits component for children, ensures a full range of services are available for children. This is a national commitment that makes sense and is eminently affordable.

There is no concept of State flexibility that would make rational the coverage of speech therapy or essential prescription drugs or hearing aids for school children in South Dakota, New Jersey, or Louisiana, but not North Dakota, New York or Florida.

Covering this full range of necessary services is remarkably inexpensive when you look at the per-child cost of Medicaid. Including the disabled kids that are covered by the Medicaid program, it is only about $1,000 a year compared to the elderly adult population, which costs over $7,000 a year.

We have attached some fact sheets to the testimony as well that give State-by-State analysis of what the Medicaid program does in each of the States of the United States.

This is not to say that there should not be greater State flexibility in operating the program, nor that there are not considerable savings that can be realized. State flexibility for the delivery of care through managed care, if carefully structured and monitored, could move toward these goals. This committee should act, however, to ensure that children and pregnant women realize improved access to quality of care, not deterioration.

We believe that Senator Chafee's bill, S. 839, I believe also cosponsored by Senator Graham of Florida, makes important strides to strike a balance between protecting children's and pregnant women's health under the Medicaid program, while granting States considerable flexibility in protecting providers from burdensome regulation.

Let me say a few words about block grants. Some Governors have testified before this committee seeking total flexibility through a Medicaid block grant to determine eligibility and benefits, while projecting that they would continue to cover children and pregnant women at current eligibility levels. We appreciate their commitments, however, we have two important concerns.

First, the major strategy for achieving Medicaid savings is managed care. However, managed care is largely untried for the populations that consume 70 percent of the Medicaid expenditures, the elderly and the disabled. States will be forced to seek additional ways to save, including changes in eligibility and coverage.

We know that, historically, States have moved to cover children and pregnant women only when minimal Federal standards have been put in place. In fact, with the current levels, in excess of 30 States had to come up to the Federal floor that was adopted.

Let me give you a quote that was reported just the other day by the director of the Missouri Department of Social Services. He predicted that low-income children and pregnant women would bear the brunt of cuts, including cuts of prenatal and preventive care, since it is politically impossible in his State to cut eligibility or services for the disabled and elderly. Children and pregnant women will be the targets for cuts because "compared to the political clout of the elderly and disabled, that is where we have to go."

So as you move forward, we look forward to working with you and continuing to provide our thoughts, work with you to find savings and flexibility, but also to make sure that this program continues its important role for pregnant women and children.

The CHAIRMAN. Who were just quoting Gary Stangler?

Mr. HAIFLEY. The director of Social Services.

The CHAIRMAN. In Missouri.

Mr. HAIFLEY. Yes.

The CHAIRMAN. Yes. I just talked to him at 9:00 this morning and I asked him what would happen. First, I had heard that he said he could cover 900,000 people—they now cover 600,000—if they had the same amount of Medicaid money they had now and no strings. He said, no, that was a misstatement. It had presumed an increase of about 10 percent a year, roughly what they get now, and that he could go from 600,000 to 900,000 if we would release the strings.

We are going to reduce the increase, there is not question about that. I think the seven percent, 7 percent, four percent, four percent, four percent, four percent may not be far off where we end up. We may have a battle about interstate allocation formulas. That has got nothing to do with who they cover, but which State gets more money and which State gets less money.

I asked him which he would prefer, a cut with the present waiver process and the strings that go with it, or the same amount of money in a block grant, and he said he would prefer the block grant, given those alternatives.

Mr. HAIFLEY. Well, Senator, it is very clear, both from positions that have been presented by Governors and others, that there are certain strings attached that deal with the children's and pregnant women's coverage that they want relief from, despite saying that they can continue to cover those children and pregnant women under a scaled back program.

The Kaiser Commission has testified here, indicating very optimistic forecasts about savings that States can realize, in managed care and in a number of other areas. They still believe that nearly six million children and other adults in families would lose eligibility coverage after reductions have taken place in reimbursements, after benefits have been cut and after managed care savings have been realized.

We are in a squeeze here—the flexibility that people are asking for to be able to fit within the growth rates that are being discussed here will have to involve eligibility, coverage, and benefits.

And for kids and pregnant women who have been the beneficiaries of a coordinated federal Congressional bipartisan strategy in coverage in trying to address infant mortality and a range of other issues, we fear a retreat and we fear that, given the insurance trends, that we are just going to be compounding the problem of the uninsured children in America.

[The prepared statement of Mr. Haifley appears in the appendix.]

The CHAIRMAN. Next, let us take Stephen McConnell. He is the senior vice president for Public Policy of the Alzheimer's Association.

Doctor?

STATEMENT OF STEPHEN McCONNELL, PH.D., SENIOR VICE PRESIDENT FOR PUBLIC POLICY, THE ALZHEIMER'S ASSOCIATION, WASHINGTON, DC

Dr. MCCONNELL. Thank you, Mr. Chairman and members of the committee. I am here as chair of the Long-Term Care Campaign, as a member of the Leadership Council of Aging Organizations, and also representing my organization, the Alzheimer's Association. I have been asked to talk about the elderly, but I want to be sure that you know that whatever I say about the elderly is not meant in any way to diminish the importance of children, poor women, and non-elderly disabled. People live in families, not in age groups, and an illness or a disability, an accident, affects the entire family. We are all in this together.

You face the unenviable task of trying to achieve real cost containment, meet the budget resolution target, and not harm people. That is a particularly difficult task when it comes to Medicaid.

Medicaid is the insurer of last resort for 4.3 million seniors. Twenty-eight percent of the Medicaid budget goes for the elderly, most of that in long-term care. It pays half of the nursing home bill, as you have heard. But it also helps two million elderly Medicare beneficiaries with their premiums, deductibles, and co-payments.

Who are these elderly Medicaid recipients? They are people like Elaine and Stuart Millon from Galesburg, Michigan. Stuart Millon worked in a small law firm, and then as a pastor for 25 years. They saved, they raised their children. Then Stuart developed Alzheimer's disease.

Elaine took care of him at home as long as she could, but she became ill at one point and he had to go into a nursing home. They spent all of their savings, their IRAs, their life insurance, down to the $17,000 that Michigan allows them to keep, and only then did

Medicaid step in. Without Medicaid, they could not afford the $100 a day nursing home cost.

It is also Ethel Lawson from Indianapolis who, at 69 years old, relies on her Social Security income of $569 a month. She cannot afford the Part B premiums of $46 a month. The Medicaid QMB program pays those for her so she can have health insurance.

What are our concerns about the budget resolution? First of all, the $182 billion cut in Medicaid is too deep. According to independent studies by the Urban Institute and Lewin VHI, about a million to more than two million older people would lose their Medicaid coverage—their long-term care protection—with cuts that deep. In 13 States, the entire home and community-based care program would be wiped out. Now, that is an area where States have begun to find some savings in Medicaid.

The QMB program, which now only covers 40 percent of those who are eligible, would be put under greater strain. And if there are efforts to get savings out of Medicare and increase premiums and deductibles under Medicare, that is going to put even more pressure on the Medicaid QMB program.

Second, the block grant will remove essential protections. The ending of an individual entitlement means the ending of any security for people like Mr. and Mrs. Millon. The ending of protections that this committee worked so hard to put in place, spousal impoverishment protections so that couples do not have to divorce in order to get Medicaid coverage, could be lost.

Federal nursing home protections could be lost. A recent study found that the OBRA 87 requirement for resident assessment resulted in a 25 percent reduction in hospitalization. That is savings for Medicare as a result of the nursing home quality protections in OBRA.

Third, the block grant would drive a bigger wedge between acute care and long-term care. Medicare and Medicaid are inextricably linked. If a person is on Medicaid and in a nursing home and needs health care, what is to stop them from being sent to a hospital where Medicare picks up the $600–700 a day? There is no incentive for the State or the Medicaid program to prevent that from happening. Likewise, people shifted from a Medicare bed out of the hospital into a long-term care setting increases costs for Medicaid.

Senator Dole understood this problem when he introduced his bill recently to expand the PACE program, which allows bringing together Medicaid and Medicare for the frail elderly. According to him, these projects have found a 5 to 15 percent reduction in Medicare and Medicaid spending by bringing together Medicaid and Medicare. By block granting Medicaid and removing the Federal responsibility, we move in the opposite direction from that. What are our recommendations? In addition to integrating Medicare and Medicaid we need to maintain the entitlement status of Medicaid, we need to maintain the joint federal/State responsibility for Medicaid and keep the States providing a match, we need to protect those who are now covered by Medicaid, including those in the QMB program and those who are eligible for long-term care.

With regard to long-term care, several specific recommendations. We need to expand the opportunities for home and community-based care which can produce savings. If you take someone with

Alzheimer's disease, studies show that it costs $12,500 to care for that person at home versus $42,000 annually in a nursing home. The reason is, the family is picking up a lot of those costs. We need to expand opportunities for that kind of home and community-based care.

We also need to decouple home and community-based care eligibility from nursing home eligibility so that people do not have to be so severely disabled to get some help at home, because that is a way that we can prevent them from ending up in an institution.

We need to retain the spousal impoverishment protections, and we need to maintain Federal enforcement of nursing home quality standards.

In closing, I feel the frustration that I know many of you do with the narrow focus of this hearing; the Budget Resolution requires us to focus on Medicaid. But we cannot get Medicaid costs under control unless we look at the larger picture, bringing Medicare and Medicaid together and ultimately containing costs in the larger health care system.

I look forward to the day we get back to that larger debate. In the meantime, we are here to work with you to try to solve this problem.

The CHAIRMAN. Doctor, thank you.

[The prepared statement of Dr. McConnell appears in the appendix.]

The CHAIRMAN. Now we have Dr. Kathleen McGinley, who is the assistant director in the Governmental Affairs Office of The Arc, formerly the Association of Retarded Children. I like the name a lot better. The Arc has a memorable ring to it.

STATEMENT OF KATHLEEN H. McGINLEY, PH.D., ASSISTANT DIRECTOR, GOVERNMENTAL AFFAIRS OFFICE, THE ARC, WASHINGTON, DC, ON BEHALF OF THE CONSORTIUM FOR CITIZENS WITH DISABILITIES

Dr. MCGINLEY. Thank you very much.

Today I am here representing the Health Task Force of the Consortium for Citizens with Disabilities. The task force consists of approximately 50 national organizations which work with, and on behalf, of people with disabilities and their families.

Medicaid is a critical health safety net for millions of people, including people with disabilities. For many of those who need long-term care, Medicaid is the only resource.

As you deliberate Medicaid changes, we think it is essential that you put a human face on the people your actions are going to affect. A child with mental retardation or cerebral palsy, an adolescent with traumatic brain injury or a spinal cord injury, a young adult with serious mental illness or multiple sclerosis, a middle-aged person with Alzheimer's disease, an elderly person with Parkinson's disease.

Medicaid provides health and long-term services for over 36 million people, including approximately five million children and adults who are blind or have significant disabilities. Most of the people with disabilities quality for Medicaid because they are eligible for SSI.

In some States, people with disabilities or their families qualify for Medicaid because they have high medical expenses in relation to their income, and a certain portion of people who qualify for Medicaid under the AFDC program also have significant disabilities. Then we have the millions of elderly people with disabilities who receive essential Medicaid services.

We are concerned that if Medicaid is no longer an entitlement millions of people will lose access to critical health and long-term services. For people with disabilities, this may lead to an exacerbation of existing health problems, the emergence of secondary disabilities, and, in some cases, something we are really concerned about, inappropriate and unwarranted institutionalization.

The CCD health task force opposes Medicaid restructuring that results in a loss of eligibility for current categories of Medicaid beneficiaries, including the medically needy population, and we recommend a continuation of federally-mandated entitlement status to Medicaid for people who are eligible for SSI.

We have to keep in mind in the disability community that, for us, this is a very broad program. It provides a lot of basic services. It is an important source of Federal and State funding, not only for acute care services, but also for long-term services, for low-income people with disabilities of all ages.

The EPSDT mandate is another example of an important program in Medicaid. It helps with the early identification and treatment of serious health and disabling conditions. For children, like a child with cerebral palsy which can impair your speech, it covers the cost of augmentative communication devices. This enables the child to communicate with their family members, with their school mates, with other people in the community.

Medicaid is the primary source of long-term services for poor elderly and younger individuals with significant disabilities. Unfortunately, approximately 85 percent of the Medicaid long-term care expenditures go to institutional care. That means only 15 percent are for home and community-based services.

However, with Federal leadership and Federal funding the States have been helped to develop home and community-based services under waiver programs, under programs like the CSLA program, and they have been able to provide personal care services as an alternative to nursing home care. These positive steps must not be compromised.

We recommend that the full array of mandatory and optional services currently provided continues to be reimbursed for, that critical services like those in the EPSDT program continue to be mandated.

We suggest that home and community-based services which are currently available only through waivers, be made simple State options. This would relieve the States of much of their paper work burden, increase flexibility, but still maintain that Federal oversight that we believe is needed.

We believe that States must continue to be required to finance comprehensive acute and long-term care services and supports, and given the flexibility and the direction to promote the use of home and community-based services.

We believe the current institutional bias must be ended and that home and community-based services and supports, such as community-supported living arrangements and psycho-social rehabilitation for people with mental illness, should be expanded.

We are concerned that if the States are given funds with no requirements the funds may be diverted to other purposes than to providing critical services that they now provide. We recommend that the use of Medicaid funds be restricted to the provisions of services currently provided through the program and that the States be required to keep at least their current level of funding.

We are also concerned that critical Federal protections, consumer protections, that are in the Medicaid program must be continued in relation both to acute care services and in relation to institutional care, and so on.

I just wanted to mention one other issue, and that is the issue of Medicaid managed care. People with disabilities, as States have moved towards Medicaid managed care programs, have often not been included for a number of reasons.

We are concerned that, as there is more and more move towards managed care, that there needs to be guidelines and protections so that managed care can work for people with disabilities, and we have provided recommendations in our written testimony.

The Medicaid program is the largest source of Federal and State funding for services and supports for people with disabilities. With Federal oversight and protections that safeguard the health, safety, and rights of people with disabilities, the States have been able to leverage Federal funds in ways that have benefitted millions.

This investment in children and adults with disabilities is critical if we are to ensure that they receive the health, rehabilitative, and other acute and long-term care services and supports that they need to achieve and maintain independence and reach their full potential.

We want to thank you for the opportunity to share our concerns with you and we look forward to working with you to help ensure that changes to the program are beneficial to people with disabilities.

The CHAIRMAN. Thank you, Doctor, very much.

[The prepared statement of Dr. McGinley appears in the appendix.]

The CHAIRMAN. Now we have Dr. Clyde Oden with us, Reverend and Doctor. He is both a minister and a Doctor of Optometry. You testified, as I recall, about a year ago, on health reform and did a good job. He runs a health maintenance organization, the Watts Health Foundation. It has got about 90,000 members, of which 60,000 are on Medicaid.

Dr. ODEN. That is correct.

The CHAIRMAN. So if there is anybody experienced in managed care for Medicaid, you are it.

STATEMENT OF REV. DR. CLYDE W. ODEN, JR., PRESIDENT AND CHIEF EXECUTIVE OFFICER, WATTS HEALTH FOUNDATION, INC., INGLEWOOD, CALIFORNIA, ON BEHALF OF THE GROUP HEALTH ASSOCIATION OF AMERICA

Dr. ODEN. Thank you, Mr. Chairman. It is an honor to testify before you this morning. I am Dr. Oden, and for the last 22 years have been with the Watts Health Foundation that has served the Medicaid population in Southern California, as a Health Maintenance Organization.

We are here today to testify on behalf of the Group Health Association of America. GHAA is the leading national association for HMOs. This 385-member group serves nearly 80 percent of the 50 million Americans receiving health care from HMOs today.

The complete text of my testimony has been provided to the committee, and I respectfully submit that presentation for the record.

Although in my written testimony I address four issues with the committee which includes the development and current status of Medicaid managed care, the experiences of United Health Plan in serving Medicaid beneficiaries over the last 22 years, the review of key problems that have arisen, and GHAA's views and recommendations with respect to the future of Medicaid, it is only the latter that I will spend the remainder of my testimony addressing this morning.

By personal experience, I think what we have seen overall is that managed care can be an appropriate option in serving the Medicaid population provided that certain things occur.

And when those things do not occur, and I am speaking now of particularly the lack of standards where States have failed to develop or vigorously enforce appropriate standards for health plans seeking to serve the Medicaid population, or where States have sought to expand Medicaid managed care too quickly, problems have occurred. But we think those problems can be overcome if attention is paid to some of the recommendations that we make.

One, is that there needs to be a commitment to the beneficiary. Medicaid should maintain its commitment to provide access to quality health care for low-income individuals and their families. There needs to be effective State implementation and enforcement of standards. States need to plan adequately for the initiation and ongoing monitoring of Medicaid managed care. Key elements of successful State Medicaid managed care programs include: adequate enrollment, disenrollment, and administrative and data systems, assistance to beneficiaries in the process of health plan selection, and enrollment and disenrollment, well-focused regulatory standards and adequate and knowledgeable staff to complement and enforce those standards, and that the regulatory staff must be able to have the ability to evaluate organizations that are new entries in providing this care, and also they must be able to conduct sophisticated monitoring of compliance with the standards on an ongoing basis.

We think that health plan standards are most important. All HMOs and other Medicaid managed care plans should meet comparable standards to ensure the integrity of participating plans, including standards for quality, access, and solvency. Standards for entities participating in the Medicaid program should be no less stringent than standards for organizations serving the private sector.

With respect to quality, plans that obtain private sector accreditation should be deemed to have met the Medicaid program standards when a determination is made that the private sector standards are at least as stringent.

Performance standards should be developed that apply to all Medicaid providers and plans, regardless of the type of payment. These measures should be carefully selected to provide a set of key quality indicators of special significance to the Medicaid population and programs.

Third, the issue of access. All programs and organizations that provide Medicaid-covered services through provider networks should ensure the availability and accessibility of services to the beneficiaries that enroll.

Critical elements include the location of providers, the hours of operation, and the arrangements for after-hours care. In addition, services should be provided in a manner that is responsive to the health care needs of the Medicaid population in such areas as cultural and linguistic competency, housing and child care, transportation needs, and other environmental factors.

The next point is one of solvency. All organizations participating in Medicaid managed care programs should meet solvency standards that ensure that they have the financial capability to provide the promised services.

As new organizations take on the responsibility for delivery and financing of care for Medicaid beneficiaries, it is critical that they demonstrate their ability to serve that population.

Finally, with regard to benefits. To permit the expansion of HMOs and other managed care plans in Medicaid, Medicaid benefits should remain comprehensive. That includes out-patient and preventive services, as well as in-patient and emergency services. Medicaid program carve-out of services should be discouraged unless they are similar to carve-out standards found in the commercial sector.

There should also be an opportunity for choice for Medicaid recipients, and there should be periodic opportunity for Medicaid beneficiaries to change plans when they are in a plan.

Finally, with respect to payment, payment needs to be reasonable, it needs to be based upon utilization and cost, and should be actuarially determined. We believe that there is a necessary role for oversight of the Medicaid program.

States should be given flexibility to be laboratories for new and innovative approaches. However, there are some things that are very clear on which demonstrations do not need to be made anymore, particularly in the areas of solvency, benefits, accessibility, quality, and payment. Those should be assured wherever Medicaid services are being provided.

Mr. Chairman, the Group Health Association of America looks forward to working with the Congress, the administration, and States in implementing careful changes to the Medicaid program, and I would be pleased to answer any questions that the committee might have.

Thank you.

The CHAIRMAN. Doctor, thank you.

[The prepared statement of Dr. Oden appears in the appendix.]

The CHAIRMAN. We will conclude with Dr. Bruce Siegel, who is the president of the New York City Health and Hospitals Corporation.

Doctor?

STATEMENT OF BRUCE SIEGEL, M.D., PRESIDENT, NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, NEW YORK, NY

Dr. SIEGEL. Thank you, Mr. Chairman and other members of the committee for inviting us to testify here today.

I am Dr. Bruce Siegel, president of the New York City Health and Hospitals Corporation, which is the largest public hospital system in America, and one of the largest hospital systems overall in America.

I have come today to discuss how we can best reshape the Medicaid program in order to achieve considerable cost savings while maintaining the ability to meet the needs of our Nation's poorest citizens.

Let me take a minute to tell you about the Health and Hospitals Corporation. Throughout New York City we operate 11 acute care hospitals, six large community health centers, five long-term care facilities, dozens of community-based clinics, the city emergency medical services, and Metro Plus, our Medicaid HMO, and in doing so we employ about 43,000 people and have a budget of $3.8 billion.

Because we operate in the city's most medically underserved areas, our patients tend to be the poorest, the sickest, and the most vulnerable New Yorkers. We treat about half of the city's AIDS patients, and over half of those who have psychiatric problems.

We also handle a tremendous percentage of the overall needs of the city, providing half of the city's out-patient care, almost a quarter of its in-patient care, and 40 percent of its ER care. Last year, we delivered over 28,000 babies, admitted more than 200,000 patients, handled over one million ER visits, and over five million ambulatory care visits.

I think it is important to understand that the Medicaid reductions now being proposed would come on the heels of the greatest budget reductions that many health care providers have ever experienced. For us, the cuts we have faced in the past 2 years are by far the largest in our 25-year history.

To cope with this, we have made changes. Last year we organized ourselves into six vertically-integrated networks, a change which has yielded millions of dollars in savings. We made major investments in our HMO, which is now the fastest-growing Medicaid HMO in the city, and now the second-largest overall, with 60,000 members.

Because of these pressures, we have also had to make difficult choices. In the last year and a half, we have reduced our work force by over 6,200 people and we have taken over 1,000 beds out of service. In response to the latest round of reductions due to the State and city's fiscal problems, we have directed our facilities to reduce their budgets by 25 percent.

As we shift our attention now to here, to Washington, we face the prospect of more deep reductions. We understand the legitimate need to reduce the Federal deficit, but we think reductions in Medicaid must be taken responsibly. They cannot fall disproportionately on safety net providers, like the Health and Hospitals Corporation, who are least able to bear these reductions.

We enter this season with even greater concern because so many of our patients are insured by Medicaid and Medicare. We receive more than 80 percent of our budget from these payors, with 72 percent from Medicaid alone.

The National Association of Public Hospitals recently estimated that under the Senate's initial budget proposal we would lose almost $1 billion in the year 2002, which would be almost 30 percent of our Medicaid payments and almost 20 percent of our total budget. Over the entire 7-year projected period we would lose more than $3 billion. These figures give us an indication of just how devastating a reduction of this magnitude would be to providers that serve large numbers of Medicaid patients.

Now, despite these grim estimates we think there are a number of steps that can be taken to minimize the adverse impact of Medicaid reductions on safety net providers and I will give you four examples.

The first, is in disproportionate share payments. Disproportionate share payments, or DSH payments, currently account for about $500 million of our revenue. Designed to defray the cost of treating the uninsured and poor, disproportionate share funds enable us to meet our mission of caring for the most vulnerable.

Proposals to scale it back or eliminate DSH would be absolutely devastating. Instead, we believe the program could be improved by targeting disproportionate share payments exclusively to the highest-volume providers of care to the poor.

Such a restructuring would make the program more faithful to Congress' original intent, while providing true safety net providers with needed relief. You could also shift disproportionate share payments from a strictly in-patient basis to also an out-patient basis to provide the right incentives for us.

The second point, graduate medical education. With the exception of the VA, we are the Nation's largest training ground for medical residents. We train 3,000 future physicians every year. Because we train so many residents, we depend greatly on their services to take care of the poor and we depend greatly on direct and indirect medical education payments to pay for that.

Reductions in support for graduate medical education would not only have financial effects, but would disrupt our ability to have a work force that can provide the care that our patients need.

Third, we need to encourage managed care. While the enrollment of Medicaid patients into HMOs has increased rapidly in recent years, there are still many barriers that prevent more rapid expansion and prevent the savings that could accrue. We would recommend that legislation be enacted that would promote Medicaid managed care by providing greater flexibility to the States while still maintaining important Federal oversights.

Finally, fairness. It is imperative that Medicaid be reformed fairly and we believe that we should avoid a significant redistribution from region to region. To those who question New York and the amount we spend on Medicaid, I would note that there are sound reasons for this. We spend a lot of money, and a lot of it is our own money.

We have a commitment to caring for our neediest citizens and we have the lowest Federal matching rate of any State in the Nation. We also must contend with serious problems of substance abuse, homelessness, and public health epidemics, all of which make our health care costs higher than the rest of America. Twenty percent of all AIDS cases are treated in New York. New York hospitals see more cases of tuberculosis than hospitals in the cities of Atlanta, Boston, Chicago, Houston, Los Angeles, Miami, and San Francisco combined.

Again, I would like to thank you for giving us an opportunity to speak to you today. We, as public hospitals, serve as the safety net for the Nation's poor. As you deliberate over a very difficult task around Medicaid, we ask that you do it in a way that recognizes the importance of preserving an infrastructure that can meet the needs of those who need us the most.

Thank you.

The CHAIRMAN. Doctor, thank you.

[The prepared statement of Dr. Siegel appears in the appendix.]

The CHAIRMAN. Let me address a general question to the panel. You are well aware of the criticism that we could balance our budget if we just cut out waste, fraud, and corruption. I discover that there is lots of it in every program, except the program that the person that is talking to me is talking about. There is no waste, fraud, or corruption in their program, or any program they like, it is in your program or somebody else's program.

Do any of you think there are large amounts of money to be saved, talking about hundreds of billions of dollars, in waste, fraud, and corruption? I will just start with Mr. Goldberg.

Mr. GOLDBERG. I do not know. I do not have any specific numbers for you so I cannot give you facts. I do know that I personally take a chronic medication and I had the occasion to buy the medication on a trip to Mexico. I bought the medication for a fraction of the price there than I can buy it over the counter here in the United States. I use that as an example.

The CHAIRMAN. That is not waste, fraud, and corruption, however.

Mr. GOLDBERG. That is the pricing of products.

The CHAIRMAN. That is correct.

Mr. GOLDBERG. That is correct. Right offhand, I think there is oftentimes duplication of procedures performed for people, some of it because of liability, some of it for other reasons that are not necessarily medically indicated.

I would hope that some of that could be resolved through how we approach managed care in the future. I would hope that the dollars we are looking at do not indicate widespread corruption throughout the system.

The CHAIRMAN. I will give you an example of what I am talking about, depending on how you view it. This may have been the Grace Commission report of 15 or so years ago, or maybe another report, alleging great waste in military pensions. That was the word, waste—they did not say fraud or corruption—and literally, scores of billions of dollars could be saved over a number of years.

But here was their argument. Today, the military pension system is, you serve 20 years you get half your base pay, you serve 30 years, you get three-quarters of your base pay. So if a kid goes in at 18, gets out at 38, he gets half pay for the remainder of his life.

The report suggested that you should not get any military pension until you are age 62. It does not matter when you get out, you do not get it until you are 62, and there would be no cost of living adjustment from the time you got out until age 62.

Well, you can save a lot of money that way, and maybe we want to consider that. But that is not a waste issue, that is a policy issue. But this report categorized it as waste. That is why I am always hesitant. My hunch is, this was written by somebody who had never been in the military.

Mr. Haifley?

Mr. HAIFLEY. Well, Senator, obviously there are things that you can do in the health care system to create incentives to use the expenditures more efficiently, and of course we support efforts like that.

One of the areas that typically comes up from a waste or abuse perspective when you are talking about beneficiary populations are allegations of over-utilization or inappropriate utilization, and during some previous hearings issues around co-payments have come up, particularly around beneficiary consumption of health care.

I just want to take this opportunity to say, I do not know to what extent over-utilization takes place. If you are looking at issues around prenatal care, trying to prevent infant mortality and low birth weights and so forth, you want to do things that incentivize people using care, not avoiding using care.

So on the co-payment front, I would just call attention to the fact that if co-payments are a part of the equation or the mix, that we should certainly continue to exempt prevention services from co-payment obligations. I would point out that the Office of Technology Assessment (OTA), in a report last year, in looking at co-payment studies said that for kids in low-income families, co-payments frequently are a barrier to access to necessary care.

So if you look at the co-payment perspective, and I am not raising it because I am an advocate of co-payments, but because it has been put on the table and the inference is that there is abuse or over-utilization, we need to be very careful not to create barriers that, in fact, lead to people delaying care, which leads to more expensive care later, and so forth.

The CHAIRMAN. Dr. McConnell?

Dr. MCCONNELL. Well, if waste is equated with inefficiency as I mentioned, the separation of Medicare and Medicaid creates waste. When we bring those two programs together, as we have in the PACE program and other demonstrations, there are clear savings that are brought about because people are getting appropriate care, and that can produce savings.

The second example that I cited in my testimony was the result of ensuring good, quality care in nursing homes. If people get good care in nursing homes they are less likely to develop other illnesses that put them in the hospital. It saves money.

This one study recently released shows a 25 percent reduction in hospitalization. So I think those are some areas where there is waste. I do not know if that is exactly how people think about it, but certainly inefficiency and inappropriate care ends up costing us more money than it should.

The CHAIRMAN. Dr. McGinley?

Dr. MCGINLEY. Well, this is one of the things we discussed as a coalition in relation to how to save money, and we talked about flexibility and streamlining, we talked about waste, fraud, and abuse. Basically, we decided that one of the best ways we saw to save money in this system was to remove the institutional bias that is in Medicaid right now and put more of an emphasis on home and community-based care.

You could say that there is waste when you consider the fact that there is so much more money spent on more costly institutional care when people could be provided services in their community.

The CHAIRMAN. Dr. Oden?

Dr. ODEN. Mr. Chairman, there clearly are problems with respect to inefficiencies. Those inefficiencies come about through an old system that really had few elements of teaching recipients how to utilize services. So we have seen, over the years, persons inappropriately accessing services, such as using the emergency room for primary care.

One could look at that as a waste, not deliberate, but as an inadvertent kind of problem that has existed and continues to exist under the old-fashioned kind of fee-for-service.

There are also, whenever there is the lack of preventive care, when there is a lack of early intervention, then more expensive care is provided. Again, you might call that or characterize it as waste, but, in fact, what it is, again, is inefficiency.

There are a number of inefficiencies that can be addressed, but it is not something for which a magical wand can be swung and overnight things change, particularly when you look at beneficiaries for a program which, over 30 years, has had very little beneficiary education, very little effort, to really talk about change in lifestyle, very little effort to deal with appropriate health-seeking behavior. Those are unfortunate instances that we see currently in the program that can be addressed.

The CHAIRMAN. Dr. Siegel?

Dr. SIEGEL. First of all, there is clearly inefficiency and there is clearly what we would call fraud. Whether or not it adds up to the sorts of numbers that you are talking about in terms of the savings we are looking for, so far, I do not believe so.

Our approach towards inefficiency has been, rather than just cutting dollars for services or cutting services, let us move folks into a good managed care approach, do it right, so that they get less expensive preventive care up front and do not seek more expensive care later. We think that will work.

Let me give you a concrete example of one way we tried to root out what we thought was a form of inefficiency recently. Because of our budget problems, we were faced with the prospect of closing our out-patient pharmacies in our hospitals which did provide, for many, completely free drugs for people, which we thought was an important service in some ways. So we did not want to close them.

What we did was say, let us look at our patients, look at who can afford to pay, and say, listen, we are going to ask you to pay $5, $15 or $20 for your drugs. You have not been asked that before.

What happened is, we found many people could afford that modest amount. The same number of people are still coming to our pharmacies, and many of them have now produced insurance cards for the first time that were not produced before.

So we think this will bring some money into our system we did not have before and continue to allow us to keep open pharmacies which can continue to serve some people who really cannot afford to pay anything at all. So there definitely are savings there, but for us, not hundreds of millions or billions.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman. Mr. Chairman, again, I want to compliment you for bringing this distinguished and very enlightening panel to give us their thoughts on these complex and important issues.

I would like to talk some about the issue of whether we should move from our current system of a guaranteed individual Medicaid entitlement to a block grant system administered through the States.

If I could align the arguments for the two positions, the arguments for block grants are essentially that it would provide for greater flexibility at the State level, and through that flexibility there would be a greater capacity to respond to the peculiar characteristics of individual States and communities and achieve at least equal access and quality of service while also securing cost saving.

The counter arguments are essentially those that Dr. McConnell made, that there are certain stabilizing factors built into the individual guaranteed entitlement that relate to changes in the economic cycle, demographic changes, and other factors that are better dealt with if looked at on a nationwide as opposed to a State-by-State basis.

I would be interested in your comments as to those two fundamentally different approaches to the Medicaid program, including the degree to which you believe that the flexibility that block grants would provide could be achieved through other means that would still maintain the individual guaranteed entitlement, what would be the effect of the Federal Government's withdrawal from some of those stabilizing components that are part of the current system?

Maybe we could start with Dr. McConnell, since he devoted a significant amount of his comments to that subject.

Dr. MCCONNELL. Well, I think one of the ironies is that in long-term care the States have a fair amount of flexibility now and they have been exercising it and we see a lot of innovation in home and community-based care. There is a lot more that could be provided. I mentioned that we need to decouple eligibility for home and community-based care from nursing home eligibility. States are ratcheting that up.

Senator GRAHAM. Is that a statutory coupling or is it a regular coupling?

Dr. MCCONNELL. I think it is part of the waiver that requires that a person, in order to get home and community-based care under a waiver, has to be eligible for nursing home care. The State can provide it as long as they provide it for roughly the same amount of money as a nursing home.

But the reality is, and I know you are aware of this, if you can intervene earlier when people are less sick you can then delay, even prevent, institutionalization. So there is more flexibility that can be built in. Somehow the distinction between entitlement on the one hand, and flexibility on the other, is arbitrary. The block grant concept has become connected to flexibility and entitlement has gotten connected to the big, bad Federal Government.

I think there is a lot of flexibility that could be built in and still maintain the entitlement and there are also things that can be done to provide some certainty, which I know all of you are looking for, maybe by putting a per capita cap on the program. It allows you to have some certainty to contain costs, but still maintain a guarantee so people have their own certainty about protection.

Senator GRAHAM. Any other members of the panel wish to comment on that?

Dr. MCGINLEY. Well, I can say something, too. I think that the disability community thinks that it is extremely important that the entitlement status is maintained because attached to that entitlement status you now currently have an assurance that you are going to have some certain specific services and you have consumer protections built in, something that we are not so sure that would continue if power or control is devolved to the States.

I think this is an ongoing concern with most of the issues that are being discussed in relation to block grants for the disability community. We are not so sure that, with this devolution back to the States, comes assurance that people with disabilities are going to be treated in an equitable manner within that State and with a variation of formulas and so on and so forth; how are they going to fare from State to State? One of the reasons that I think the disability community is so strong on maintaining the entitlement and maintaining some type of Federal presence is the fact that, historically, the States—a long time ago, hopefully—were not doing a very good job about providing services to people with disabilities.

Sometimes when they did the job, the job they did was not a great job, it was in a large institution, and so on. Bringing the Federal Government into that has changed that situation. At the same time, there is a great deal of flexibility, we believe, like Steve said, built into the long-term care part of it, flexibility that could be expanded.

Mr. HAIFLEY. Senator, I would say that the entitlement versus the block grant question, from a maternal and child health perspective, I mean, you can look at the entitlement as being the contract between the Congress and America's children and pregnant women for coverage for the scope of their services, just like the insurance card that I carry in my pocket is the contract that my employer has engaged in with the insurance company that provides my coverage.

To the extent that we go to a block grant approach, clearly that contract with America's kids and pregnant women is significantly changed, if not completely eliminated. Suddenly you have a whole population of people for whom, for very good, very broad Federal policy reasons, we have decided to provide coverage and a set of benefits to these people.

There is considerable flexibility in income levels that States can go to, the waiver process allows States a range of flexibility that they can engage in with regard to the kids and the pregnant women that are in the program now. I would echo the notion that this talk about flexibility is not all on the block grant side, it is on the entitlement side, too.

I thought that it was really striking in Mr. Vladek's testimony yesterday that 50 percent of the State spending on Medicaid is on optional coverage and optional benefits. I mean, that tells me that there is a lot of flexibility that States are exercising to get to the spending levels where they are right now under the Medicaid program.

Mr. GOLDBERG. Senator, I do not need to tell you about Florida. Probably it is a bellwether State for what the rest of the United States will look like very, very soon. Your 85 plus population and the migration of elderly over 65 going to the State is very, very dramatic. How does one adjust for those types of changes?

One of the interesting things, the first response from most States in this country when they started running low on funds a few years ago was to pass a granny tax. In essence, the frail, elderly persons who were private-pay in nursing homes were taxed to make up the State's match. That happened in 26 States, and is still going on in this country.

They are the frail, elderly people who have to come up with the State's share of the Medicaid match. That makes me have grave questions about the commitment or the willingness of the States to provide high quality health care.

I think there is tremendous flexibility. There, perhaps, needs to be more flexibility in the 1115 waiver to do some of the experimentation that Oregon has been doing and a few other States have been taking on.

The other thing is the economic vicissitudes. In this country right now, California is having severe economic problems, whereas the Midwest is doing much better. How do we adjust for those types of disparities? Our view is that probably the best place to handle some of the decision-making is at the Federal level.

The point I also made earlier is about the myth that there is a great deal of money being made in operation of nursing homes. I represent not-for-profits exclusively. We do not make money on doing nursing home care under the Medicaid program. I will suggest to you that for-profits do not make a lot of money either.

They make it in the ancillary service sides of the care system, pharmacy, therapies, and other types of program areas, but not in providing the basic services of the nursing home. Our concern is obviously the States' willingness to be creative and the sheer number of sicker patients that we are going to have to be dealing with in the future.

Dr. SIEGEL. Senator, I think for us the devil is in the details on block grants. We support flexibility to the States and we think we can do more of the things we need to do in managed care, which are important to us for the future. It is a good idea.

The problem becomes, if it is part of any sort of block grant methodology or accompanying methodology, what we really start to see is money starts to dry up for indigent care, for medical education, for those sorts of bread-and-butter issues for us for things we need to do. So it is hard to sort of react to what is better or worse unless we really know what is going to be the bottom line impact on us.

Dr. ODEN. Senator, also the devil may be in the definitions, too. Our English language is sometimes inadequate in looking at these kinds of issues. But if you look at Medicaid as a health services program that is nationally sponsored with some State partnership, it is hard to imagine other national programs like FEHBP or Medicare or any national employer having radically different programs for the population for which they accept responsibility.

So, yes, there ought to be flexibility, but at the same time there needs to be a core set of standards for which one can assure that certain things are being accomplished.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. Thank you, Mr. Chairman.

We have had in past meetings witnesses come before the committee who have stated or implied that managed care plans do not have enough experience with the elderly or with the disabled, and because of so little experience these witnesses have implied reservations on their part about the ability of managed care plans to adequately take care of people with disabilities, and then at the same time, I suppose what faces this committee, is having to save money.

So with those reservations that have been stated, I guess Dr. Oden, you would be the one I should ask first, would you agree that managed care plans have had little experience with people with disability and then consequently, what are your Association's thoughts on whether managed care plans are going to be able to take care of the old and disabled as managed care plans come to be more used in Medicare and Medicaid?

Dr. ODEN. Thank you, Senator. We have had 22 years' of personal experience. I think that would speak to the fact that, for more than two decades, we have served the disabled and the elderly. We started in the most poverty-impacted part of Southern California, serving low-income elderly, low-income disabled persons.

We have found that, through our own personal experience and through those of our colleagues, in fact, HMOs and other managed care organizations can serve those populations.

What is required in every instance is that the same kinds of expectations for an organization serving those vulnerable populations be held as one would have serving commercial populations.

With regard to saving money, certainly there can be savings, but one has to take the long view rather than the short view. It is not a matter of instantaneously turning anything overnight. But I would take issue with anyone who would suggest that there has not been enough experience. I think our record speaks to that and I would challenge anyone to look at that record.

Senator GRASSLEY. All right. So you are accepting the fact that managed care plans can, from your point of view, take care of people with disabilities.

Dr. ODEN. Yes.

Senator GRASSLEY. And also the elderly.

Dr. ODEN. Yes.

Senator GRASSLEY. All right. Maybe one other short comment. I do not want to ask everybody to comment. Dr. McGinley, you might be an appropriate person. I have a couple of more questions, that is why I do not want a long comment.

Dr. MCGINLEY. Well, I think that right up front I want to say that, as managed care has emerged, as mandated Medicaid managed care has emerged as a concept in the past few years, we have been concerned but we have also realized the fact that this is something that is coming.

The data that we have, and I think there is more data in the written testimony, is the fact that most of the States that have mandated Medicaid managed care programs have exempted people with disabilities, so less than one percent of the population of people with disabilities is now served.

We realize what is going to come. We are saying, if you are going to have managed care, and we understand there are benefits in the coordinated care aspects of managed care, but we are saying that there have to be protections provided for people with disabilities, for people who are elderly, and so on, and so forth, in managed care.

Many of the points that Dr. Oden mentioned in his talk are the exact same points we make related to solvency and those types of issues. We want to make sure that if it is a managed care program it is a program that is equipped to meet the special health care needs of children and adults with disabilities, people who often have special long-term relationships with providers.

So, we will continue to raise concerns, but we will also continue to provide recommendations that, if this is going to be, let us make it work the best way possible.

Senator GRASSLEY. So then if they work, you argue, for appropriate standards. I think you said that, Reverend Oden, particularly the vigorous enforcement of them. But you did not make clear whether or not you have a position on whether or not these ought to be set by the Federal Government or by the State governments.

Dr. ODEN. I think they ought to be national in terms of those standards. It should be Federal Government.

Senator GRASSLEY. Do you have model standards that your association has prepared?

Dr. ODEN. Our association has worked with the national regulatory agencies in terms of those standards. Yes, they do exist.

Senator GRASSLEY. All right. But your association itself has not come up with what it considers its own model standard?

Dr. ODEN. I cannot speak specifically on that. I know very clearly that GHAA has worked with the national insurance regulators, as well as HMO regulators, on a national set of standards, so I know there has been agreement there. So I guess, in a sense, working backwards on that, the answer would be yes.

Senator GRASSLEY. All right.

Can I ask one more question?

The CHAIRMAN. Yes.

Senator GRASSLEY. Mr. Goldberg, you asked for a reassessment of the nursing home rules from a cost benefit perspective. Tell me to what extent that reassessment should be, and would you have maybe two or three examples of rules that you think should be altered?

Mr. GOLDBERG. I can think of a number of examples. If I could be permitted to pick up on one point from the last question. There is a concept called CCRC. As a matter of fact, there is a company from Iowa Life Care Services Corporation that has developed it. They are basically managed care environments for seniors moved into a housing program with health care and other services.

A study by the Wharton School of Finance in 1982 found, number one, lower utilization of Medicare because of fewer hospitalizations. The study found that CCRC's added 3 years' life expectancy to a 78-year-old person, the average age upon admission, along with lifestyle improvements in terms of resident's functioning. These communities were set up by non-profit organizations, usually religiously-sponsored, and they are very typical of a managed care type of organization. Properly done, managed care can work well in these situations.

In regards to nursing home regulations, there are a number of things. We are very involved with looking at assisted living today. One of the things we found that perhaps could be a new efficiency is the creation of what we call a universal worker. Under this system, workers would do a number of different things for the person rather than having the services carried out according to professional titles, such as nurses, nurse aides, dietary attendants, and so on. The system is similar to athletic cross-training.

This system is not permissible under current rules and regulations, but by cross training people we think there could be efficiencies and a better response to the people who are cared for in those nursing homes. There are a number of other regulations, such as some of the requirements coming from OSHA which go beyond what is necessary and beyond what the States and the Federal Government willing to pay for under the Medicaid program.

Those issues are very classic examples of the cost benefit ratio between the regulation and what it costs to comply with it. Nursing homes have come a long, long way since the days when they really, truly needed a heavy amount of regulation.

We are not ready to deregulate this industry, but there are a number of pieces that need to be looked at, and looked at carefully, where I think we can achieve some cost savings. There still is a need for a Federal presence to maintain a watch over nursing homes.

Senator GRASSLEY. I do not have any more questions. But is there any way Dr. McConnell could comment on that, particularly from the standpoint of, do you feel that there should be no changes whatsoever in Federal regulations as they exist today?

Dr. MCCONNELL. Well, I think it is clear that we need to reexamine some of the regulations, but I think to just throw the baby out with the bath water would be a real problem. I think there is a need to sit down with the industry to examine what works and what does not, but there are examples of things that are working. I mentioned the resident assessment requirements in OBRA 87 which are reducing hospitalization, the requirements that chemical and physical restraints be reduced.

The nursing home industry thought that was not going to be possible until it was put into law, and then suddenly they lined up and they are finding out they are producing much better care, it can be done.

So there is a lot of good that has happened, and we need to maintain that. But to say that everything is perfect as it is, I would not say that. I think we need to just be very cautious about this. Certainly just lifting regulations because regulations are "bad" would be a serious problem.

Senator GRASSLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I attended a hearing a couple of weeks ago put on by Families U.S.A., in which there were not heads of organizations or experts or HCFA directors, but in which there were human beings who were to be affected by some of these cuts that will be made in Medicaid and Medicare. I found that a much more instructive and much more interesting hearing than what I have heard so far and what I have read in terms of the testimony.

We have had four hearings on Medicaid. We have had Governors, we have had Bruce Vladek, we have had experts, and we have had you. We have had no people whatsoever. This, in the face of the largest cut in Medicaid in the history of this country. Well, back since 1965.

Now, I was struck that when the Chairman opened his questioning that he immediately started talking about waste, fraud, and abuse, not any effect as to how it would be on people, but what kind of waste, fraud, and abuse were you all guilty of. The you, I believe, Dr. Oden, referred to inefficiencies, which I thought was good. I guess one of the questions I would have for you is, why in God's name did you not ask the Chairman of this full committee, where the heck are the details that you, sir, asked for, the devil is in the details, and you have no idea what kind of cuts in Medicaid and Medicare are going to do, and what is going to happen in GME as far as Medicare is concerned. You have no idea, none whatsoever. The biggest cuts in history.

I would like to go down this panel, each one of you. Dr. McConnell talked about a human incident in his testimony. Dr. Goldberg, not in his written testimony, talked about a human incident, a human person. All the rest of you are reacting to numbers, plans, parameters, but none of you, in a sense, to what it is the American people are terrified about.

We went through the Health Security Act for 2 years with spectacular success: we accomplished absolutely nothing. But there certainly was a lot of time to think about, what happens if we cut back on Medicaid and Medicare, and we have had a lot of time since then. As far as I know, the Chairman of this full committee has no intention of putting forward any details, either on his own instructions or by order of the Majority Leader, than till September, or perhaps even into October, when we have markup, so that you are going to be flying in the blind, having no idea, sitting there simply making generic answers to generic questions or talking about inefficiencies as opposed to waste, fraud, and abuse.

And I would like to know why, if you are so concerned about your constituents—and you, Dr. McGinley, with 4.9 million people, if they get what I think is going to happen to them on Medicaid, are going to get pitched out on the streets because they are not going to be able to get any kind of health insurance whatsoever, much to speak of, Dr. McConnell, on your people, or Mr. Goldberg.

I would like to have each of you tell me why you did not ask the Chairman of this committee, in some form or another, when am I going to get the details so that not just you members of the Senate go back from your August recess you can start digesting this and working through this with your people, but that you as professionals and representatives of major fields are not demanding this kind of information from us in the U.S. Congress.

The House is. The House Ranking Members have written a letter saying, we cannot do this until we have hearings based upon details. All we have now are generics and broad statements, $270 billion in Medicare and $182 billion in Medicaid.

So I would like to have each of you answer why you did not, in some form, put pressure on us to give you the details of these cuts so that you know what the heck you are going to be dealing with.

The CHAIRMAN. Let me correct just a misinterpretation that you may have, Jay, on waste, fraud and corruption. It was a rhetorical question. I do not think we can do it on waste, fraud, and corruption. I do not even think we come close on waste, fraud and corruption, although I did see headlines in The Des Moines Register that Senator Harkin had a hearing in Des Moines indicating that it could be done on waste, fraud, and corruption. But I regard that as a straw man that people use to avoid tough decisions.

Senator ROCKEFELLER. That is correct.

The CHAIRMAN. So, I just do not want them to answer with a misimpression. I did not mean to give that impression with my question.

Senator ROCKEFELLER. Panel members, starting with you, sir.

Dr. SIEGEL. All right. We have actually been, in our conversations with Senate staffers and other people we have talked to here, trying to get information, to get details. Obviously that is still being worked out. And one of the things I hoped to do in my testimony when I was trying to run down some of the things I think we need to do, especially in the disproportionate share area, was perhaps give some ideas about what some of those details might be so that you can get to some of the goals that you need to get to and we can still do the things that we think are important.

Senator ROCKEFELLER. So you have been talking to Senate staff members?

Dr. SIEGEL. Yes.

Senator ROCKEFELLER. Minority and Majority?

Dr. SIEGEL. We maintain a presence here full-time and we do talk to both Majority and Minority and try to get our concerns across, and get information in return.

You also referenced a human side of this. I would say two things to that. My concern in this, in the human side of this, is that we not disenfranchise further millions of people, including those in our city but in many other places, too, who have been at least partially enfranchised, at least by what Medicaid has done in the past. Yes, there are problems with Medicaid. Yes, there are problems. You can call them inefficiencies or waste.

Senator ROCKEFELLER. Can I go on to the next person, sir? My time has run out. The Chairman can cut me off, but I hope he will not.

Reverend Dr. Oden?

Dr. ODEN. Thank you, Senator. The staff from GHA has, in fact, been meeting with Senators and staff to talk about details to the extent details can be wrestled with. Our president, Karen Ignani, I know, has met with you to share her concerns.

Senator ROCKEFELLER. Did she divulge the intimate degree of details that I was able to give her about what the Majority is planning on doing? I enjoyed the meeting.

Dr. ODEN. I think there were some blank spaces, yes.

I want to respond to another point that you made.

Senator ROCKEFELLER. I do not want you to. I want to go down this, because the Chairman has——

Dr. ODEN. Well, no. It is within the same framework.You talked about the human issue and the human factor. I come from an organization that is a consumer-run organization. The concerns are real. We are not talking about theoretical people. So it is important that whatever changes are made are done in a way that does not hurt people and, in fact, can continue to help in whatever way possible.

So we do not look from any cavalier position at all in terms of what is currently going on, we are responding as best we can to this political environment. We know change is going to come. We know that with respect to change in terms of managed care and Medicaid, that many people are looking in this direction in terms of how it can be helpful in addressing——

Senator ROCKEFELLER. Dr. Oden, I would like to go on to Dr. McGinley, if I could, please.

Dr. MCGINLEY. All right. Well, I can start out, too, and say, yes, we have been meeting with the staff also and we were pleased, because there were not that many details, to have the chance to come here and give some input. I represent The Arc, which is an active nationwide disability organization. We represent seven million people with retardation.

I also am here today representing the Consortium for Citizens with Disabilities, which I think most of you know well, as very active nationwide and in Washington on a whole lot of different issues. If we had had our druthers, there would have been a consumer up here today, too. And I do not want to sound like I am making excuses.

Almost every single program that we have an interest in is under attack in some form or another, so we are spread a little bit thin. But we saw this as an opportunity. We were pleased that we were asked to have some input. We thought that this was an opportunity to maybe help shape something that was going to be positive.

Senator ROCKEFELLER. Optimistic.

Dr. MCGINLEY. Yes.

Senator ROCKEFELLER. Dr. McConnell?

Dr. McCONNELL. Well, Senator, as you know when you talk to people out there about these proposed changes, I often get the response, “I cannot believe they are going to do that. I simply cannot believe that the United States Senate would cut this program that much.”

So, in effect, my charge here today was to try to communicate that disbelief and that concern. We need details, but I do not know how any details at this point can come up with solutions to the kinds of numbers that we are talking about.

I do not think details will solve the problems that have been raised by people that I am here trying to communicate for. We need those details so we can understand the program better, but just what has been put out there, it just does not seem conceivable that it can be done.

Senator ROCKEFELLER. Mr. Haifley.

Mr. HAIFLEY. Senator, from the maternal and child health perspective, obviously, I cannot speak or articulate the issue in any fashion that is going to be as effective as you all visiting a children’s hospital that typically gets its revenue from Medicaid services that they provide to Medicaid-eligible children, or to visit a public hospital neonatal unit, which I did just recently, and saw tiny infants starting out at some of the most incredible disadvantages in life, but who are there and surviving and have the opportunity to develop and grow and become productive members of this society because of what Medicaid does in covering them. I cannot do that. And your question makes me very uncomfortable, because you are absolutely right.

Senator ROCKEFELLER. What about the first part of my question?

Mr. HAIFLEY. The first part of your question is, what I am doing here is to lay the base work for you all for the hard decisions that are going to come before this committee, and we certainly appreciate the chance to be here to do that.

At the back of the testimony that we have distributed are fact sheets for every State represented by a Senator on this committee saying what Medicaid does in terms of coverage of children in their State, pregnant women in their State, how many babies’ deliveries are covered, how much uncompensated delivery costs have gone down in their State.

The inference is, obviously, that with numbers the size that we are talking about, obviously there is going to be pain involved. All I can do at this point is lay out the facts and hope to communicate the human face of it, and obviously I cannot do that as well as those infants who are so desperately depending on this program.

Senator ROCKEFELLER. Mr. Goldberg.

Mr. GOLDBERG. Senator, I am here to ask you to stop. There are no details. What we hear coming from the House side is very, very scary. What is it going to amount to? Without the details right now we are going to go back to warehouses for the old people.

We are going to have Mrs. Smith, who has to go to the bathroom and there is no one there to take her because the facility cannot find sufficient staff willing to work in those types of environments for lower wages. I think we are talking about draconian cuts and I think we are talking about a system that simply will go back to where we were perhaps 100 years ago in terms of how we are providing care.

So, without the details present, based on the rumors I am hearing coming from the House, we have to assume that we are going to take a giant step backwards and the suffering will be enormous in terms of how people are cared for. These cuts are enormous.

When one adds to this the number of elderly people coming into the system and they are much sicker, it does not work. So without these details being known, we actually beseech you to stop this process.

I will take one step and probably get myself in trouble. We are looking at this issue of the tax cut. I do not hear the American people anyplace—and I travel extensively—who say, give me a tax cut. We got into the problem of the deficit over a period of time. And when I do that in my own personal home, it takes me a period of time to resolve the problem.

So what I would suggest is, put the tax cut away, let us go forth and find the cost containment we can, let us solve the problem, whether it is 7 years or 10 years, and take a more reasonable approach to dealing with some of these issues.

Senator ROCKEFELLER. Thank you.

The CHAIRMAN. Senator Bradley.

Senator BRADLEY. Thank you very much, Mr. Chairman.

This little discussion is about details, which I think are incredibly important, but it is like all of you being on a boat and then having a big torpedo hit the boat and the boat is gushing water, and somebody saying, can we have the details on how we keep the boat afloat? Because what you are saying is that a lot of people are going to go under with this set of cuts.

I think that is what Senator Rockefeller's frustration reflected—that he knows that a lot of people are going to be hurt by these cuts and that we cannot seem to get a focus on it because we are going to end up with a bum's rush at the end. We will have a week to do it and we are going to be part of a giant package. I think that is what his fear is, and I think that it is possibly a legitimate fear.

How could it be anything other than the boat going under if we are going to block grant Medicaid, dramatically cut it, deny you getting money from public insurers or having much ability to cost shift? What is going to happen?

I am glad Dr. Siegel, who is a distinguished former Commissioner of Health in New Jersey and one of the people responsible for bringing New Jersey State health insurance reform is the first to raise his hand to respond.

Dr. SIEGEL. I have been called lots of things, but that is the best so far. [Laughter.]

I have two fears about this, and you mentioning New Jersey actually made me think of something. I mean, in New Jersey a couple of years ago we were talking about how to insure more people and we were talking about how to do that in a cost effective way. I think we made at least the first baby steps in that direction, and that is still playing out.

What I see here is perhaps the opposite discussion because, with this level of reduction being talked about, you are really faced with, I think, two unappealing options, either cut back payments to institutions like ours so far that we provide essentially just low-quality or no service and we already see higher rates of infant mortality, we see higher rates of measles, we see things like tuberculosis just go up and up and up, which in the long-run will cost us more, or the other option, which may lead us to the same place, is just to start saying, all those folks who we brought in to some form of insurance, very imperfect, called Medicaid, let us start moving them out now, let us deinsure large numbers of people. As a physician, I find that objectionable because I know that will have a direct impact on the health of those individuals.

But I think also, somebody who is forced to work in a system which is, in many ways, an economic system, I also find it tough. If you start having millions of people walking around now without insurance who had it before, you start really destabilizing that system.

And for those of us, like many others, who do not have an insurance company who you can raise the bills to to pay for the poor who do not have that, you really enter a spiral because what you do is you start eroding your services, fewer people come to you, they are sick somewhere else not getting care, and you provide less quality of service and you eventually go under. Those people are still there, they are just not getting health care.

Senator BRADLEY. Well, that is a very clear and ominous picture. What about the two-thirds of the people who are in long-term care who are paid for by Medicaid, how can you cut dramatically the Medicaid portion that goes to take care of long-term care, and what will happen to those individuals that are now in nursing homes paid for by Medicaid if you slash it? What will happen?

Dr. MCCONNELL. Well, Senator, a person with Alzheimer's disease is not suddenly going to be able to start taking care of themselves. I think what is going to happen is that the first thing to be cut will be the home and community-based programs which, as you know in your State, and in Oregon, there has been tremendous success in bringing down costs and providing more appropriate care. Those are going to be likely to be cut first because it is going to be difficult to throw people out of nursing homes. So what we are going to do is eliminate the one hope for producing better care and cost savings.

In New Jersey, according to our estimates, there will be about 68,000 people by the year 2002 who will lose access to long-term care, mostly home and community-based care, because of these cuts.

Senator BRADLEY. Where are they going to go?

Dr. MCCONNELL. They have no place to go. The only reason a person ends up in a nursing home, generally, is that the family simply cannot do it any longer. They do it as long as they can, and then a person goes to a nursing home. There is no way to bring those people back out of a nursing home, in most cases, and give them back to the family. The families cannot do it. Also, twenty percent of people with Alzheimer's disease have no family.

Senator BRADLEY. So my question is, where are they going to go?

Mr. GOLDBERG. I think we are going to go back to the alms homes and the poor farms of the past. I agree with Steve McConnell on this thing. Home and community-based services are the first light at the end of the tunnel of integrating people back into the community. People may have been placed in nursing homes inappropriately, but only because there have been no other community resources. We talk about where they are going to go. We are going to cut standards, we are going to cut wages, and we are going to cut staffing.

And I used Mrs. Smith as an example. Mrs. Smith will stay in that bed, develop bed sores, develop decubiti. Not being able to have someone assist her in the bathroom will create other kinds of problems for this individual.

That is what we came from historically and I am fearful that that is where we are going to go in the future with these types of cuts which are being proposed, both eliminating the idea of home and community-base services and keeping them in the nursing home and cutting the resources.

I say that only because, looking at an average of four percent increase, look at the number of over age 85 people who are vulnerable and coming into these homes. There is no way we can do it.

The second point I just want to make is that the nursing home attendant, who represents 70 percent of the facility's costs, has one of the lowest wages and one of the toughest places of work any human being can deal with. It is hard work, it is gut-busting work, and I tell you, it is very poorly compensated. You pull something out of this, what do we have left except for warehouses?

Senator BRADLEY. Now, I know my time is up so I want only want one person to respond, if I could ask a quick question. You have got policy makers down here in Washington that are not stupid.

I mean, they are proposing these draconian cuts. And they hear you coming in here and they will have their staffs reporting back to them what you said. And they will say, we do not think that will happen, we are willing to take the chance, because that is what anybody who supports these draconian cuts have got to say. What do you have to say to them?

Mr. HAIFLEY. Senator, in my testimony I was very clear about that. We do not question the good faith of Governors who come in here and say that we are going to continue to cover pregnant women and children.

Our response is, we do not see how you can carry through with that commitment, no matter how sincere it may be, because we are talking about a pie that is going to be substantially reduced, constricted beyond you know what inflation is going to be in the Medicaid program, and people are going to lose coverage.

Senator BRADLEY. So what you are saying is, more and more politicians' rhetoric will be here, and reality will be here. Politicians' rhetoric will say, oh, things are working out fine. We cut, we are saving money. These people are going to be all right.

Meanwhile, you will find more infant mortality, more people who are not able to make it in nursing homes, more people who are warehoused, less care, more tuberculosis.

The purpose of the politicians who speak like this is simply to avert the gaze so you do not see this unpleasant fact that is emerging in larger and larger dimensions in America. Is that not right?

Dr. McGinley. It is obvious that the population of people that are being harmed by this are the population of people who are the most disenfranchised, the people who are the least verbal, vocal constituency. Yes, I believe exactly what you are saying is happening.

Senator Bradley. You mean, there is no Medicaid-PAC.

Dr. McGinley. Not that I know of.

Mr. Goldberg. Senator, you asked the question as to how we addressed this issue with our staffs going back. And I would have to say that anyone who has gone through the experience of caring for a parent, gone through the experience of putting a parent in a nursing home, being part of that sandwich generation, I almost have to say, who is going to care for you? And that means every member of Congress, and anyone else.

With these kind of cuts, you really are dealing with those issues. You have to form a vision in your own mind as to where this thing is going and it is not a very pretty one, and it is not very pleasant.

Senator Bradley. I thank the Chair.

The Chairman. A year and a half ago Dr. Reischauer testified before this committee on the Health Security Act for President Clinton's bill and he said, if everything worked right, the Congressional Budget Office estimated that it would reduce by a full percent our health care spending over a decade, from 20.5 percent of our Gross Domestic Product to 19.5 percent. Senator Durenberger said to him, but it is 14 percent now. That is going the wrong direction.

This was if everything worked right in the plan, all of the insurance caps worked, and we were going to tell the training hospitals what kind of doctors they could train and where they would have to go. If everything worked right, our costs went up dramatically. There was a general feeling that at some stage there has got to be some limit to the amount of our Gross Domestic Product that we spend on health.

Under the so called cuts that we are talking about now, our spending will go up from about 14 percent of Gross Domestic Product to someplace between 17, 17.5, maybe 18 percent. It is not going to go down. On Medicare, we are talking about trying to restrain the increase from 10 percent a year to 7 percent a year. Increase. On Medicaid, we are talking about trying to restrain 10, 11 or 12 percent. It bounces about from year to year, to 7 percent for a couple of years, and four percent after that, increase, not decrease.

As to the lack of details, I plead guilty at the moment. Our normal process is to hear from people before we do the details. I suppose we could reverse the process, have placebo hearings, and say we have already decided all the details, and if you want to comment on them, that is fine, but we are not going to change them. That is not the normal process. We have been meeting with you.

But here is the question I want you to help me with. I understand why every group is often split, even within itself, let alone when forced to go toe-to-toe with some other group. We operate under a majority vote in the Congress. The Budget Resolution has ordered restraints in increases. That is what I will call them.

On the entitlement side, $620 billion in reductions from the increase, still tremendously up. This is not the discretionary spending, the appropriated spending, this is the entitlements. Pardon me, $632 billion. Of that, $530 billion is in this committee. We have to save $530 billion.

Now, here is our problem. This is a presumption, we can reach this $530 billion any way we want within the programs we have in this committee, but the presumption is $182 billion for Medicaid, $270 billion for Medicare, and then $78 billion from all of the other programs that we have, and that is welfare, SSI, Supplementary Security Income, the Earned Income Tax Credit, Trade Adjustment Assistance, Unemployment, everything else we have put together.

And, to the extent we do less in health, i.e., Medicare and Medicaid, we have got to do more out of that $78 billion total, and we have to go to $88 billion, $98 billion, or $108 billion if we go down in health.

Given that, before we write the details—and the answer is, do not do it—what do we do? Dr. Siegel says, do not hit us too hard on disproportionate share hospitals. You are treating a disproportionate number of poor in New York. I went to NYU law school. I know what you are doing. More than any other State, you train doctors. Mr. Haifley says, do not do anything to pregnant women and children.

I understand that. How do we get to our totals?

Mr. HAIFLEY. Senator, you have been dealt a very bad hand, I would say, by the Budget Resolution and you have our sympathy.

The CHAIRMAN. Yes. But I have to play this hand.

Mr. HAIFLEY. I understand.

The CHAIRMAN. I cannot ask for another deal.

Mr. HAIFLEY. Obviously, with Medicaid, our position would be that the best way to approach savings from the program is to start with programmatic changes that make good health policy sense. Do not start from an arbitrary number that is a very bad card in the hand that you have been dealt.

There are proposals, I know, that are floating around and substantial savings that can be made out of disproportionate share while still preserving aspects of it, to keep providers afloat to be able to serve the populations that we care about. We are accepting the fact that managed care is here for the population that we advocate for and expect that there are going to be savings that can be realized there.

I would say that we need to look at the program from a programmatic standpoint in that fashion and see where you get and deal with that rather than starting with the assumption that we can arbitrarily slice $182 billion out of the program and not have to cut pregnant women and kids off, or people who get long-term care, or the disabled.

The CHAIRMAN. Dr. Siegel?

Dr. SIEGEL. Mr. Chairman, I understand the dilemma you are in and I am not trying to in any way make light of it. I am trying to propose, at least two concrete ideas, some of which are programmatic, in which you can save money and probably provide just as good care, if not better.

Probably the biggest umbrella for that is to do managed care, do it responsibly, do it with Federal guidelines, and do it in a way that makes sense, that people get care up front and do not have to get it later on. I do not think it will get to every dollar you need, but it will save you billions.

Second, on a disproportionate share front, I think the Federal Government could save billions of dollars every year by refocusing this program. It is our sense that it is very broad. In many States, every hospital is a disproportionate share hospital. That does not make a lot of sense fiscally or programmatically and you could target it to provide better indigent care and save a lot of money.

The CHAIRMAN. Any other comments?

Dr. ODEN. Senator, I would agree with Dr. Siegel in terms of that perspective. We would want to impress upon this committee and this Senate that HMOs and other managed care delivery systems are not a cheap alternative. It is not something where you can just arbitrarily pick a number and then expect to have quality care coming out the other side.

There are savings to be had, but to arbitrarily set some numbers or to have States create new organizations under the name of managed care and to experiment on our citizens would be the worst thing to do.

Standards have to be there, they have to be vigorously enforced. We need to use the experiences of the past and make certain that those experiences are emblazoned in public policy. But the ultimate answer may be, you cannot get there from here.

Mr. GOLDBERG. I think it is an issue of integrated public policy. Let me use an example. There is a program called Section 202. It is a housing program for low-income people. We surveyed our members who are participants. They said the number one issue of concern was aging in place. How do you keep Mrs. Smith in her apartment when she starts to deteriorate so we do not have to send her to a nursing home? They did not ask for more money, they said, how do you solve the problem?

The issue is very simple. You have a care coordinator, someone who can come in and help bring in some of the services from the community. You know what, we unfunded it.

So Mrs. Smith, who now has some problems but could remain in that independent housing now goes to the nursing home. We are advancing the PACE program. I know Senator Dole has advanced it. It is a wonderful program.

The number one factor, they tell me, that helps keep people out of nursing homes is adaptive housing, a decent house where you can get into the bathroom, you do not have to crawl upstairs, and you have doors which you can wheel a wheelchair through, and there is adequate nutrition. We are still dealing with the health care issue, but these aspects are not noted. You put health care people and housing people in the same room, they do not even talk the same language because we have never integrated the programs. I think it is a crucial solution. The hand that you have is a bad one. It is grossly unfair. The question was asked, what do we say to you? I think we have to go back and reassess the plan. We have to cut costs. We know that is a fact of life.

Our hope is that we can stretch it out, give it some time so we can figure out where we are going, because in the short time we have I am sure we are going to make too many mistakes and then we are going to be resistant to come back and look at it. My hope is to buy a little more time, stretch it to 10 years till we hit the targets, and try to deal with this in a more rational way than this piecemeal way. I mean that with no criticism whatsoever. Your hands are tough.

The CHAIRMAN. No, I understand. This is the hand that has been dealt to me and I have got to play this hand. I am reminded of that wonderful last scene in Butch Cassidy and the Sundance Kid where Butch and Sundance are holed up in the little room and the Bolivian army has got them surrounded, and they go out with their guns blazing, "We got them right where we want them."

Senator BRADLEY. Mr. Chairman, I remember a different scene in the same movie. Several times they say, "Who are those guys?" [Laughter.]

The CHAIRMAN. Bob.

Senator GRAHAM. Well, I think we are not talking about health policy, we are talking about what I would call political bait-and-switch. What we are being given here is the idea that there is some magic world that will be achieved by placing the States in full control of this provision of health care finance to the poorest of Americans, and that through that magic flexibility, that we will not have any degradation in access or quality of care.

After that bait has been accepted, then we are going to find the switch, which is, this is just a means of hacking away at a program that is vulnerable for people who have relatively little political power and will suffer serious consequences, and that those consequences will not be equally distributed.

It is not an accident that the Governors who have been the most vocal advocates of this block grant approach are Governors with populations that are relatively stable or declining so they can take a constant amount of funding for a period of years into the future, not with no consequences, but with lesser consequences.

In States like mine where the population is growing rapidly, it will be rapacious in terms of the impact that our people will feel. So there should not be any disguise as to what we are talking about. It is not a health discussion, it is a political discussion driven by who has power and who does not have power.

Let me ask about a couple of things which are driving the Medicaid program and ask if you have any indication that they are going to be significantly altered.

Yesterday, Dr. Vladek, in his testimony, showed a pie chart which indicated the number of Americans in different sectors of the health care financing world. One of those sectors was the uninsured, and there were some positive comments made that, over the last few years, the percentage of uninsured has stayed constant at around 16 percent.

But if you looked further at the pie chart, what you saw is that the number of people covered by private insurance was dramatically declining and that that decline was being picked up by Medicaid enrolling more people. That was a shift of approximately 10 percent of the American population from private-pay to Medicaid.

Do you see that decline in private coverage stabilizing or reversing, or are we going to continue to see more and more Americans not covered at the point of employment and looking to Medicaid, either for themselves or their dependents?

Mr. HAIFLEY. Senator, let me address that, because it has been raised in the context of the expansions for pregnant women and children specifically in previous hearings. The trends of disinsurance by the private sector, employment-based private insurance, for kids, has been tremendous since 1987. We can track it—in my testimony I track it—from 1977 to 1987.

Now, it may be true that with Medicaid expansions part of the private sector loss has been offset because of the expansions, but they cannot be identified as being kids who lose private insurance who then move into Medicaid, because it does not work that way.

In addition, the expansions may have had a bit of an offsetting effect, but at the same time, the private insurance coverage for kids, the trends have continued despite the expansions to the tune of 800,000 kids a year losing coverage, and we project that out to 2002. You can look at, there are going to be 13 million uninsured kids just based on what is going to happen in the private sector between now and 2002 without any changes to the Medicaid system whatsoever.

Senator GRAHAM. And if you have the changes that are being contemplated in this Budget Resolution, what will be the effect?

Mr. HAIFLEY. It will be substantially more than 13 million children. We do not know exactly how many. We do not know how the Governors and the States are going to allocate the cuts, but it will contribute to the loss of coverage to the private sector.

Senator GRAHAM. Let me ask about another trend that is occurring, and that is the increase in the percentage of Americans over the age of 85. In my State, there are now approximately 1.5–2 percent of population is over the age of 85. It is the fastest-growing sector in our population.

By sometime early in the 21st century, it is projected that 3 percent of Floridians will be over the age of 85, and that sometime in the first quarter of the 21st century that may be the profile of the Nation.

Do you see any reversal of that demographic increase in the number of people at those advanced ages, and what is the significance of that to Medicaid and its provision of services to the elderly and the disabled?

Dr. MCCONNELL. To the contrary, that part of the population really is the result of our success in making people healthier. They are living longer, albeit with disabilities.

Our acute care system has made them healthier, now they need long-term care. That will not decline. It will continue to increase. That is a good chunk of where the cost increases to Medicaid are coming from. It is the population that needs help and there are not many other places to which they can turn.

On the private insurance side, it is kind of a flip-side of your earlier question. If we hold out a hope that private insurance for long-term care will help us solve this problem, it is kind of an empty hope at this point. By the industry's own standards, only about 40 percent of the elderly can afford long-term care insurance. The real growth in the market will come among younger people, if you can convince them to buy it.

But that is a solution that will not even begin to kick in for 30 or 40 years, so we will not see any significant relief on the Medicaid program as a result of private insurance for many years, and even at its most optimistic assumptions it will not come close to solving the problem.

Senator GRAHAM. Thank you.

The CHAIRMAN. Jay?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

A couple of points. The question has been raised from both the panel and from those on the committee dealing with the concept of the hand that we have been dealt as if it were something that came down in tablet form from some ancient oracle.

It is my reasonably clear impression that this was voted on by the U.S. Congress and then that the Majority party in the House and the Senate got together to discuss the magnitude of the cuts, but something really, I think, of great interest, and that is something called a tax cut.

Now, the tax cut, as I understand it—and let me put this in a political context—every single one of the 54 Republicans voted for this budget bill, which is the hand that has been dealt us within very recent time. Every single Democrat voted against it. That is being very political, but those are the terms I choose to put it in at this point.

Then there was a $245 billion tax cut. If the tax cut had not been there, the Medicaid cuts that we are now discussing could have been eliminated and there would be $63 billion left over yet for tax cuts for wealthy and other people who are desperately crying out for these things.

Now, I am not suggesting that there should not have been cuts in Medicaid and Medicare. We made cuts in Medicaid and Medicare in 1993 when we extended the life of Medicare by several years. What I am suggesting is that, along with what the Chairman quoted Dr. Reischauer of saying, is that Dr. Reischauer also said on Medicaid cuts that it would cut provider payments.

I have no idea how you are going to handle GME, but I will just tell you that the House is estimating there will be $27 billion of cuts in GME. So that is one detail you can look forward to.

It would cut benefits and it would cut people off assistance wholesale. That has also been said by the Republican-appointed director of the Congressional Budget Office, Dr. O'Neil. She agreed that none of those were inaccurate statements.

The statement has been made that, with the Health Security Act, the costs would have gone up very substantially. That is, of course, correct. I think, in fact, it as not 17 percent, but I think they went up to 19 percent as opposed to the 20 that they otherwise would have gone up to. But there are two small details, just for the purpose of being honest about this, that I think ought to be put on the record.

One, is that after the year 2010, the cost of health care began to decrease as a percentage of GDP. That fact was not mentioned. Nor was the fact that one of the reasons that the cost of health care was going to go up was that there were approximately 60 million Americans or more who have no health insurance at this point who were going to be included. Obviously, that does not happen without increased cost.

I would conclude my observation, and that is that reference has been made to what will happen or what is happening anyway with the private sector reacting to non-action on the part of comprehensive health care and the rest of it; whether it was a Clinton plan or not is not an important part.

The General Accounting Office, which I think is fairly well respected around here, has said that by the year 2000, which is less than four and a half years from now, that 50 percent of Americans who work for companies—who work for companies—will not have health insurance, and that a goodly number of those who do have health insurance will have health insurance themselves but will not cover their dependents. So the world is, indeed, changing. As Mr. Goldberg said, it is not getting any more pleasant.

Thank the Chair.

The CHAIRMAN. Jay, what was your source on percent of GDP going down in 2010?

Senator ROCKEFELLER. I will get that for you.

The CHAIRMAN. All right. Thank you.

Senator Simpson?

Senator SIMPSON. Well, I just wandered by here and could hear the pangs of pain ricocheting down the hall. Fascinating business. It is my first here on the Finance Committee. I have a whole host of new friends never dreamed of, some of the most bizarre questions and entreaties that I have ever been aware of, and the most arcane of all time.

But I was on the Entitlements Commission. I am going to say it again. I love to hear everybody talk about the cuts, savagery, the ugliness that will be inflicted upon the kids—this usually with violin music—the seniors, the veterans, the lesser poor, the disenfranchised, the disemboweled, and everybody in this room knows that Medicare will go broke in 2002. You know it, everybody in this room that has got half a brain knows it.

It is the trustees telling us that, it is not some mysterious oracle from outer space. The trustees consist of Robert Rubin, Robert Reisch, Donna Shalala, Shirley Chater, and one Republican and one Democrat.

They are telling us that Medicare will be broke, bankrupt, exhausted in the year 2002, and the Disability Insurance will end or go broke in the year 2016, and that Social Security itself will be broke in the year 2031. We have moved that date from 2063 in 1983 to 2031 in 1995. Everybody, I think, understands that. It will begin its decline in the year 2013 and we will go cash the bonds, which will be the double hit.

I will vote in a few weeks on a $5 trillion debt. $5 trillion. This is your government. We did it. Everyone at this table had a hand in doing it. A $5 trillion debt limit. If we do not extend, the green checks will not go out. I know that, you know that.

Medicaid has been ripped apart by the States with their creativity over the years, how to get more money out of the Federal Government and how to do it by gimmicking Medicaid. Some were totally creative, magnificently creative. Let us not forget that. Let us not forget that.

I always say, why do we not quit messing around with the wealthy who pay taxes. Why is it the wealthy get a break if we reduce taxes? It is because the wealthy pay the most taxes.

But I have a new proposal. We are not going to mess around. We should not just tax the rich, we should take it all. Just confiscate all of Wal-Mart and the Buffet, get it all, the Fortune list, the Forbes list, every yacht, every ranch, every stock certificate. That will run the country for about 7 months, ladies and gentlemen. That is about $700–800 billion. The budget this year is $1.56 trillion.

If anybody wonders about the lesser in society, let us hear them talk about why we left off the table, Democrats and Republicans alike, an item costing us $360 billion a year that we cannot touch, Social Security, where if we could just get a cost of living allowance on people who are affluent we could fund everything hereafter. And here we sit. You know it, and I know it. I get tired of it.

I had a hearing the other day on the insolvency of Social Security. Nobody showed up. I did not hear anybody show up. All the people that go to the floor about, what will happen to Social Security, we cannot let them rob it, well, show up, because it is going to go broke.

This is fascinating business. Absolutely fascinating.So keep babbling and keep telling us about what is going to happen to the poor, the wretched, the children, and everybody. And know that all of this, according to the Entitlements Commission—and there was a lot of good work there, you have got to go read it, it is not hard, it is in English—it tells us what is going to happen to your country and mine if we do not do something and start now. We cannot even get a start because of the partisan rhetoric riotous, outrageous statements about protecting the very people who will be most destroyed.

Senator ROCKEFELLER. Would the Senator yield?

Senator SIMPSON. I would be delighted to yield for a moment, as long as I get a little rebuttal.

Senator ROCKEFELLER. You will. Am I not correct that in the Entitlement Commission, in which I think there was no vote held, for probably fortuitous reasons, but a letter sent to the President that from that perspective and this idea of saving Medicare, the cuts envisioned in the Republican budget will extend the life of Medicare. I know the answer, I am just curious if the Senator from Wyoming knows how long it will stand the demise of Medicare.

Senator SIMPSON. Well, I would say to my friend from West Virginia, I have been here 16 years and I have never seen any figure that was correct, so I do not intend to put much credence on it. We were told that when Senator Moynihan went to work in yeoman fashion that we had saved Social Security till the year 2063, and right now we have only saved it to 2031. So I am not really going to put much credence in that.

I will just say this, that 30 of the 32 members of the Entitlements Commission at least addressed the problem honestly and could not correct it because the members kind of have a little trouble dealing with powerful groups, senior groups, veterans groups, groups that cow them. They have a lot of trouble with that.

So all we know is that, with no increase in revenue—and I hope you will hear this correctly—having done a perfect health care bill—which is absurd, we will never get that done in my lifetime, a perfect one; we will do incremental reform—that in the year 2013 there will only be sufficient revenue to pay for Medicare, Medicaid, Social Security, Federal retirement, and interest on the debt. There will be nothing, absolutely nothing, to pay for education, transportation, defense, or any other discretionary program of the Federal Government. That was a decision and a ruling by 30 of 32 people, some who are here on this committee.

Senator ROCKEFELLER. To the Senator I would again just pose a question. In 1993, when we cut back on Medicaid and Medicare—in this case Medicare—by, I think, $59 billion, if the Senator from New York can verify that——

Senator MOYNIHAN. I surely can.

Senator ROCKEFELLER [continuing]. I think we extended the life of Medicare by about 3 years. I believe the Republican proposal before the Congress now would extend the life of Medicare by about 5 years.

So it is the 5-year extension and what that brings as opposed to the suffering. Is that really a long-term solution to Medicare? In fact, is there any long-term solution for Medicare contemplated in this budget?

Senator SIMPSON. I would say to my friend, not unless you reduce the increases, the annual increases, in Medicare or Medicaid. And under this Budget Resolution, this horrific horror story, this evil, foul thing dipped out of the barrel at the first act of MacBeth, is an annual increase in Medicaid of 7.2 percent. And when the people of America are told that a 7.2 percent increase in Medicaid is a cut, they deserve what they are going to get. And when Medicare goes up 10.5 percent and we are going to let it go up only 6.9, that that is a cut, they are going to get what they deserve.

As long as there are people hanging around a $700–800 billion honey pot, the bees are going to continue to draw on that. That is where we are in this country with this huge resource which has managed to be depleted beautifully by doctors, lawyers, providers, hospitals, durable goods people, who are highly skilled in this area. That is the way it works.

The CHAIRMAN. Before I call on Senator Moynihan, I ran similar figures, Alan, on the confiscation of income and wealth. I think your $700–800 billion figure has got to be confiscation of both income and wealth all at once, we just take everything, and run the government for half a year.

I actually had the Joint Tax Committee run for me how much money we could raise if we confiscated all income above $100,000, and then above $200,000. Well, they said they had never run figures like that, but they could tell me how much untaxed income was left that we do not already tax above $100,000 and $200,000.

So they told me how much we could raise if we used the untaxed income at a 100 percent rate, at $100,000 and above, and $200,000 and above. But I am just going to round off figures, as I recall them.

The first year we would raise about $150 billion, the second year we would raise about $180 billion, the third year we would raise about $210 billion, and it went up each year for 5 years. They do 5-year estimates. So I called the then director and said, do you mean to tell me that at a 100 percent rate of taxation you expect increases in tax collections each year? He said, well, we presumed no change in behavior; this is the static estimate. You are saying if we take it all people will still keep making all this money? What he said probably is not logical, so he sent me another letter, and the last paragraph is wonderful.

He said, if the 100 percent rate of taxation was to remain in effect indefinitely and if the taxpayer had no hope of deferring income to out years when the rate might be lower, and they had two or three other qualifications, then we would expect a significant downturn in economic activity and a dramatic fall in government revenues. It is just simply stated exactly that way. We cannot make it on taxing the rich. There are not enough rich, that is the problem. I have no moral objection to taxing the rich, but we cannot——

Senator MOYNIHAN. If there are not enough rich, what the hell did we have 12 years of Republican government for? [Laughter.]

The CHAIRMAN. We did not succeed in making enough.

Senator MOYNIHAN. I thought that was the plan. I mean, we went along so we could tax someone.

The CHAIRMAN. We did not succeed in making enough rich. That is what happened. [Laughter.]

Senator MOYNIHAN. Oh, no. [Laughter.]

The CHAIRMAN. Only now that the lawsuit has been settled did we apparently succeed in the teaching at law schools, where the American Bar Association, in its certification of schools, required before certification that payment levels had to be at a certain level, and if you did not pay that, you were not certified by the ABA, no matter what.

It did not matter if you were a great teacher, nothing else mattered. There the levels of teachers at law schools went up rather dramatically during that period. Whether or not there was an increase in the quality of law schools, I do not know, but all of those that raised their salaries got certified.

Senator Moynihan?

Senator MOYNIHAN. We also, Mr. Chairman, have had occasion to note that the Hippocratic oath, where this subject finds its origin, is mostly concerned with the pay of doctors and their responsibility to train and look after the family of other doctors. It gets on to not cutting for the stone much later. Life was ever thus, even on the island of Samos.

Two further things I would like to say. We got some powerful testimony from Dr. Vladeck that prices are moderating.

He had Medicaid costs growing at about 2 percentage points above inflation. This is a changed environment, something not different from that which Dr. Elwood indicated to us a year ago he saw coming. And this year Jackson Hole—Jackson Hole is in some State, I do not know, it is over there past the Mississippi—has reported similar findings. [Laughter.]

Dr. Ellwood said they had what he thought to be their most important meeting in 30 years. He said, we seem to have exercised some control over cost increases. Managed care costs went down 1 percent last year. Now is the time to focus on the issue of quality. This is an ordinary succession.

I think it has become apparent that the welfare State is no longer functional just about anywhere in the world. We should not be surprised about that. It is not the result of our misbehavior. In any case, the world has been going on for a long time and has not ended yet.

Senator SIMPSON. We will both meet out in Wyoming and we will chat about this over some light wine or ale.

Senator MOYNIHAN. White wine and ale.

Senator ROCKEFELLER. You will be in Wyoming. I will not make it.

Senator SIMPSON. He is one of my constituents, I think.

Senator MOYNIHAN. No wonder you were so nice to him. Now I understand. [Laughter.]

Thank you for your courtesies.

Senator SIMPSON. Thank you.

Senator MOYNIHAN. Mr. Chairman, yesterday I asked the panel a question about block grants, which would eliminate the contributory role of the Federal Government to the States. And I asked all five members whether they would be in favor of block grants as are now being proposed.

Let me now ask the current panel how many of you would be in favor of moving to a block grant system on Medicaid? Mr. Chairman, once again as you observed yesterday, the "nays" appear to have it. [Laughter.]

The "nays" have it.

The CHAIRMAN. No, no. The nays appear to have it. [Laughter.]

Senator MOYNIHAN. Well sir, you need to find yourself a panel on which there will be a few hands raised. Now, the vote is no. You might want to note, exactly 10 to 0.

I thank you for the opportunity, sir.

The CHAIRMAN. Folks, I have no more questions. Thank you very, very much.

[Whereupon, at 11:45 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF DONNA CHECKETT

Mr. Chairman and members of the committee, I appreciate this opportunity to testify about a restructured Medicaid program and the need for increased state flexibility. I am here to testify on behalf of the American Public Welfare Association (APWA), the non profit bipartisan organization founded in 1930 that represents the 50 cabinet-level state human service departments, hundreds of local public welfare agencies, and thousands of dedicated individuals concerned with social welfare policy. I am also speaking as Medicaid director for the state of Missouri.

For years, states have provided high-quality, cost-effective services to vulnerable populations including the frail elderly, the disabled, and low-income women and children. There are currently 36 million people enrolled in the Medicaid program. Of these, low-income women and children make up only 27 percent of Medicaid spending even though they represent roughly 73 percent of the beneficiaries. The elderly and the disabled account for 27 percent of the enrollees and 69 percent of spending, largely because of their need for both acute and long term care.

We recognize and appreciate the need for slowing the growth in federal spending, and we understand that reforming entitlement programs, including Medicaid, is necessary to achieve this goal. In this effort, states have repeatedly sought greater flexibility from federal rules and regulations so that we may use our resources to better serve eligible individuals. Medicaid spending has risen steadily, not only for the federal government, but also for the states; it now accounts for an average 20 percent of all state spending. As federal mandates have increased, state spending has increased. If federal financial support is reduced, then the need for greater state flexibility in program management takes on greater urgency.

Last week, APWA's National Council of State Human Service Administrators adopted a comprehensive set of recommendations for Medicaid reform. The full text of these recommendations is attached for the record. I would like to highlight several recommendations for the Committee this morning: first, the need for enhanced state flexibility, regardless of what mechanism is adopted by Congress to reduce federal spending; second, funding issues, including a new and creative allocation proposal; third, the future of existing waiver programs in a restructured Medicaid program; fourth, the inter-relationship between Medicaid and Medicare; and fifth, the need for an adequate transition period to implement changes. APWA has not recommended whether Medicaid should remain as a federal entitlement or whether it should be converted to a state entitlement block grant, if Congress restructures the current Medicaid program with restricted federal funding.

STATE FLEXIBILITY

It is state officials who administer the Medicaid program. However, each state's ability to manage Medicaid is sorely constrained by federal actions. States have been allowed some discretion in determining eligibility, benefits, and payment rates. But over the past decade, Congress has narrowed that discretion by mandating coverage of specific populations, specific benefits that must be offered, and payment rates that must be paid to certain providers as well as special mechanisms for nursing home admissions. These new mandates are contributing to the escalating costs of the Medicaid program and are adding to its complexity. Here is a sample of costly federal mandates and other prescriptive federal rules added by Congress over the past few years.

First, the Boren amendment, while intended to provide states with some freedom in developing institutional reimbursement policy, has evolved through court actions to become a financial nightmare, drastically limiting the states' ability to set reasonable rates for facility services. APWA calls for the repeal of the Boren Amendment. Second, Congress has mandated that states must pay certain providers, notably those established under the federal programs for Federally Qualified Health Centers and Rural Health Clinics, 100 percent of their costs. This requirement should be repealed as well.

Third, comprehensive health care for children is a national concern, yet the screening of Medicaid eligible children according to pre-determined periodicity schedules established under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program often complicates continuity of care, and results in duplicative and sometimes unnecessary services and costs. APWA calls for a modification of this requirement.

Fourth, states attempting to control Medicaid expenditures have opted to enroll Medicaid eligibles into managed care organizations. However, existing limitations on contracting with managed care plans, such as the requirement that Medicaid and Medicare beneficiaries together may not comprise more than 75 percent of plan enrollment, continue to limit states' ability to effectively manage the care of these individuals. These limitations must be eliminated.

Finally, if Congress restructures the Medicaid program and reduces federal funding by $182 billion over the next seven years, then APWA recommends that the responsibility for setting eligibility, benefit,and payment levels be given to the states.

FUNDING AND ALLOCATION RECOMMENDATION

One of the major issues stalling Senate consideration of welfare reform is the equitable allocation of federal dollars among the states. Medicaid poses a similar challenge. We have developed a new and creative proposal to address the Medicaid allocation issue.

Allocation Formula

APWA recommends that state allocations be based on expenditures incurred during the fiscal year immediately prior to enactment of Medicaid reform, and that the states be guaranteed that funding level as well as annual increases agreed upon in the statute for the following two years. The rates of growth should be higher in the first two years in order to assist states in making the transition to a restructured Medicaid program.

Further, APWA calls for the establishment of a bipartisan commission that will make recommendations to Congress regarding the adjustments that should be made in federal payments from Fiscal Years 1998 through 2002. The commission should consider adjustments based on a variety of factors including economic conditions, benefit levels, eligibility criteria, population growth, and other demographic factors.

Contingency Fund

Some states may find that, even with increased flexibility, they will be unable to avoid drastic cutbacks in their programs. In addition to the costs associated with the transformation of existing state Medicaid programs over the long term, states will have to deal with unforeseeable events such as natural disasters, higher-than-expected growth in the number of Medicaid eligibles, or sudden economic downturns. Funding must reflect the fact that the calculation made for a base year might not include the full annualized cost of program changes or partial-year program costs. To enable states to successfully implement a redesigned Medicaid program, APWA strongly recommends the establishment of a specific state option contingency fund that would be separate from other federal Medicaid allocations.

Waivers

For many years states have been allowed to make changes in their Medicaid programs, beyond what is allowed by federal statute, through waivers obtained by formal applications to the Secretary of the Department of Health and Human Services. These changes have enabled states to implement different service delivery arrangements that provide greater cost containment or service access. Waivers are approved in three major categories: those that limit the choice of service providers; those that enable states to use home and community-based services instead of institutional care and those that permit state demonstrations of new approaches to service delivery. States appreciate the efforts by the Health Care Financing Administration (HCFA) to improve these processes, but the waiver application, approval, and renewal process is still time-consuming and costly. APWA recommends that the federal requirements that necessitate waivers be eliminated.

Ten states—Arizona, Tennessee, Oregon, Hawaii, Rhode Island, Kentucky, Florida, Ohio, Delaware, and Massachusetts—have received federal approval to operate statewide Section 1115 waivers to demonstrate service delivery innovations, especially expanded use of managed care. Vermont expects formal approval later this month. Seven more state applications are pending. These states have invested a great deal of effort and resources in these waivers, and have shown good-faith efforts to control costs.

We are concerned about the fate of these waivered programs under any proposed Medicaid changes. APWA recommends that states that have Section 1115 waivers approved—or submitted by July 1, 1995, and subsequently approved—should have the option to continue to operate those waiver programs under the terms of the agreement negotiated with the federal government. If a state chooses to continue its waiver program, and to do so would result in federal expenditures that exceed federal allocations to that state, federal funds for this purpose should come from a separately identified fund, and not be taken from the overall federal dollar pool. Furthermore, if a state chooses to discontinue its waiver program, it should not incur a penalty for failure to achieve budget neutrality requirements during the years that the waiver was in operation.

INTER-RELATIONSHIP OF MEDICAID AND MEDICARE

Both the Medicare and Medicaid programs provide health insurance for the same individuals: the lower-income elderly or disabled. State Medicaid programs buy Medicare Part B coverage, and pay the co-payments and deductibles for persons receiving Supplemental Security Income (SSI) benefits. In addition, states are required to buy both Part A and Part B Medicare coverage for elderly or disabled persons—called Qualified Medicare Beneficiaries, or QMB—whose incomes are too high to qualify for SSI benefits, but are below 100% of the federal poverty level. The QMB coverage was mandated by Congress in OBRA 1988, and was to be funded from the money states would save as a result of expansion of Medicare coverage of nursing home services and prescription drugs. In 1989 the Medicare expansions were repealed, but the state mandate to provide QMB coverage remained. In fact, the mandate was enlarged to include Specified Low-income Medicare Beneficiaries (SLMBs), whose incomes are between 100 and 120 percent of the poverty level. Today, state expenditures for these two groups alone are projected at nearly $4 billion a year.

The Congressional budget resolution assumes Congress will identify ways to spend $270 billion less for Medicare benefits over the next seven years than is projected under current law. If those reductions are achieved through increasing beneficiary cost-sharing liabilities and raising the Part B premiums, some of the Medicare savings will result in increased Medicaid costs, because Medicaid will pay those premiums and deductibles. This would be an unacceptable cost shift to the states.

The implications of Medicare changes for the Medicaid program, however, go well beyond the issue of premiums costs and co-payments. These two major programs—Medicare and Medicaid—are designed to support our most expensive patients. Medicare funds the hospital and physician care, and Medicaid pays for the nursing home, extended care, and drugs for thousands of the very frail elderly, for example, persons with Alzheimer's disease, cancer patients, stroke victims, and persons with AIDS. Yet the programs operate on two separate tracks, with different funding sources, different administration, and, in the House of Representatives, even two different authorizing committees. Thus no one entity can manage the care of these individuals.

APWA recommends that, at a minimum, states should have the flexibility to manage the care of dually eligible individuals by enrolling them in managed care and to tap both the Medicare and Medicaid funding streams to pay those costs. In the absence of this flexibility, the federal government should assume full financial and program responsibility for this population.

TRANSITION PERIOD

Any federal change in Medicaid triggers a series of changes that must be made at the state level due to administrative practices or state laws. These changes involve significant challenges for the implementation of any restructuring of Medicaid. The attached chart on "Steps Required to Make a Significant Change in a State Medicaid Program" details the process states must follow to implement changes in Medicaid. While the total amount of time needed from conception of the change to its actual implementation will vary depending upon the magnitude of the revision, even a minor change in reimbursement policy cannot be put into effect by any state overnight.

In consideration of the necessary changes that states must implement, Congress should assist states in making information system and administrative program changes during the transition period. In addition, states will likely be operating multiple systems during the transition period. For this reason, there should be no penalties, sanctions, or other liabilities associated with the implementation of the new system.

CONCLUSION

Congress is proposing to reduce Medicaid spending by $182 billion over the next seven years. The most important factor to consider when designing a restructuring of Medicaid is that there are people behind all these numbers. Medicaid clients must be considered as well as the states that administer Medicaid programs. Medicaid is not just a state bureaucracy that can be painlessly downsized. Reduced federal funding can translate into fewer services for beneficiaries and fewer individuals receiving benefits. This means fewer low-income pregnant women, children, frail elderly, and disabled individuals receiving the services that they need, fewer services available to those who need them, or it could mean lower payments, and perhaps less willing providers, for persons needing services. Medicaid is the safety net for the poorest and most vulnerable individuals in this country. Any drastic changes that are considered in the Medicaid program should be made with regard to what happens to these individuals. States will try to preserve the Medicaid safety net, but we cannot do it without flexible tools, adequate funding, and an appropriate transition period.

I thank you again for this opportunity to testify and I would be happy to respond to any questions.

Attachment.

APWA Policy Recommendations on Medicaid Reform

The purpose of the Medicaid program is to finance health services for traditionally vulnerable populations such as low-income pregnant women and children, elderly, and disabled persons through a federal/state partnership. States are committed to continuing to fulfill this purpose by maintaining programs that provide these populations quality and adequate health services and by remaining accountable for the state and federal funds provided for the program. In turn, state Medicaid programs must have the flexibility necessary to continue to perform these functions if federal financial support is reduced.

Whereas, the federal and state governments have a shared responsibility to meet the essential health care needs of our nation's most vulnerable individuals and families in a manner that maximizes cost-effectiveness and efficiency; and

Whereas, the U.S. Senate and House have each adopted budget resolutions that would limit federal Medicaid funding over the seven years from FY 1996 through FY 2002 to rates that are less than those forecast for Medicaid under current law and regulation; and

Whereas, if any state's annual Medicaid expenditures increase at a rate that exceeds the proposed federal rate of increase, it could be forced to increase its state Medicaid expenditures even as federal spending is reduced; and

Whereas, a state's ability to manage and control its rate of growth in the current Medicaid program is constrained by federal rules and mandates relating to eligibility, coverage, reimbursement, and service delivery; and

Whereas, even within constraints imposed by federal rules, states have undertaken numerous successful efforts to control Medicaid expenditures, including enrollment of Medicaid-eligible individuals in managed care systems, investment in primary care and preventive health services, use of community-based alternatives, and aggressive purchasing strategies; and

Whereas, state governments have an ongoing responsibility to be accountable for the quality and adequacy of services provided to Medicaid-eligible individuals and expenditure of federal funds:

Therefore, be it resolved that the budget savings and budget certainty that Congress wishes to bring to federal spending must recognize the need for additional flexibility in state Medicaid program design and administration. This flexibility must include eliminating federal requirements mat limit a state's ability to manage Medicaid in a businesslike manner as a prudent custodian of public funds, or that result in a shifting of costs to the states; and

Be it further resolved, that states should be given responsibility to establish state-specific policies on eligibility, benefits, reimbursement levels and methodologies, service delivery systems, and provider standards, and that such state-specific policies shall not require federal approval for their implementation; and

Be it further resolved that states accept responsibility for establishing procedures to assure state accountability for quality and adequacy of health services and the expenditure of state and federal funds; and

Be it further resolved, if Congress acts to limit federal Medicaid funding, then the full amount allocated to each state should be awarded to each state annually, without regard to the actual level of expenditure for any population group or service category; and

Be it further resolved, that costs borne by states that are driven by federal policies should be fully funded by the Federal government; and

Be it further resolved that future changes in Federal Medicaid funding or in the structure of the Medicaid program must provide for a transition period sufficient to allow orderly implementation of these changes by the states; and

While APWA has not yet reached consensus on whether Medicaid should remain available as a federal entitlement to needy families or whether it should be converted to a state entitlement block grant, if Congress restructures the current Medicaid program with restricted federal funding, APWA recommends the following Medicaid policy changes:

Policy Recommendations Applicable to a Restructured Medicaid Program

Eligibility

States are interested in setting eligibility levels which are realistic and fair. States are also interested in establishing eligibility processes which are simple to understand and administer.

States should be given the flexibility to set eligibility levels for receipt of Medicaid services. While this flexibility should include a state option of setting eligibility standards for legal non-citizens, responsibility for the full cost of medical services to illegal aliens should be assumed by the federal government.

Should Congress set priorities for coverage of certain groups, it should not mandate the specific eligibility criteria to be used in determining Medicaid eligibility for individuals in these prioritized groups. States should be given the flexibility to decide these issues.

Benefits

States should be given the flexibility to determine benefit levels and covered services. If under a capped entitlement, then states should have the latitude to provide a service which is not otherwise part of the Medicaid benefit package, but should not be required to do so.

States should have the option to establish a therapeutically appropriate formula for prescription drugs with no conditions.

States should also have the option to operate pharmacy programs to control costs and/or assure patient quality through mechanisms other than the drug rebate or Drug Utilization Review systems required under present law.

Provider Standards

States should be given the flexibility to establish and maintain provider standards, recognizing the importance of cultural and professional competence, such as the current board certification requirements for obstetricians and pediatricians. The current requirements regarding the use of PASAAR, and the mandated inspection of care for ICFs/MR should be eliminated. The restrictions on composition of managed care plans, such as the 75/25 limitation, should be eliminated.

Waivers

States are interested in the ability to operate their programs in the most effective way possible, using strategies that may include those now available through special waivers and federal approval.

If a state chooses to discontinue its waiver program, within 90 days after the completion of the first session of the state legislature following the date of enactment of federal Medicaid reform it should not incur a penalty for failure to achieve budget neutrality requirements during the years that the waiver was in operation.

Federal requirements that necessitate Medicaid waivers should be eliminated.

States with approved Section 1115 waivers, or states with waiver applications submitted by July 1, 1995 and subsequently approved, should have the option to continue to operate under those waivers under the terms of the agreement negotiated with the federal government.

If a state chooses to continue its waiver program, and to do so would result in federal expenditures that exceed federal allocations to that state, then the additional federal funding for this purpose should come from a separately identified fund. This fund should not be deducted from allocations to other states.

Delivery Systems

States are interested in delivery systems which assure access to quality care at a fair price. States should be given the flexibility to develop or to buy into delivery systems, including managed care systems, or to use innovative systems to meet the needs of special situations or populations. States are committed to state-adopted programs and requirements that will assure quality and adequacy of services.

The current statutory language limiting the dually enrolled in a managed care plan should be repealed.

States should have the flexibility to impose enrollment restrictions and prohibit unlimited disenrollment to achieve greater eligibility continuity. States should be allowed to contract with a single health plan or provider.

Coverage of the Dually Eligible

States should have the flexibility to enroll in managed care and manage the services and funding streams for the Medicare/Medicaid dually-eligible elderly and disabled. In the absence of this flexibility, the federal government should assume full financial and program responsibility for these individuals.

Reimbursement

States are interested in acting as a prudent purchaser of health care services in every situation. States expect that public funds should not be used to pay more for a service than other purchasers pay in the health care market place. States should be given the flexibility to establish provider reimbursement rates and utilize competitive purchasing strategies.

The Boren amendment and the federal requirement for cost based reimbursement for Federally Qualified Health Centers and Rural Health Centers should be repealed.

States should have the option to adopt the policy that no payment made on behalf of a Medicaid beneficiary who also has other insurance, especially Medicare, should result in a total payment that exceeds the maximum amount permitted under a state's Medicaid payment schedule.

States should be allowed the flexibility to establish and impose co-payments for certain services or populations.

The federal requirement that payment to nursing facilities and ICF/MRs be based on "the highest practicable functioning level" should be repealed.

States should have responsibility for setting policy regarding transfer of assets, estate recovery, liens, and third party liability.

Allocation

The initial basis for allocation among states should be the state's expenditures incurred in federal fiscal year 1995 or the most recent fiscal year immediately preceding the effective date of the Medicaid reform statute. States should be guaranteed that base year level of funding plus agreed-upon annual increases for the fiscal years 1996 and 1997 or the first two years immediately following the effective date of the Medicaid reform statute.

Further, APWA calls for the establishment of a bi-partisan commission charged with making recommendations to Congress regarding what adjustments, if any, should be made in state allocations, and annual rates of growth to take effect in federal fiscal year 1998 and through federal fiscal year 2002. The commission should consider adjustments to state allocations based on economic conditions, benefit levels, eligibility criteria, population growth, and other demographic factors.

State Option Contingency Fund

APWA recommends the establishment of a state option contingency fund that provides access to a limited amount of federal matching funds. For some states, enhanced flexibility would prove sufficient to achieve the goals of the program. Some states may need to make additional investments in health care for vulnerable populations, such as;

- States with high population growth;
- States experiencing economic downturns; or
- States transforming their existing Medicaid programs.

A state option contingency fund would facilitate successful implementation of a redesigned Medicaid system by allowing states the option of a limited amount of additional federal support to meet these needs. Federal spending on this contingency fund would be limited in three ways. First, states could only access these supplemental funds in a given year if in the previous year they had spent as much for Medicaid as they spent in fiscal 1995. Second, the amount any state could draw down in a given year would be capped at a small percentage of its Medicaid allotment unless it was experiencing a substantial increase in unemployment. Third, a state would be required to match these federal funds at the federal Medicaid match rate.

Litigation

Congress should ensure that the private right of action in federal courts is prohibited.

Transition

States should be allowed adequate time to reform their programs. This includes consideration of state needs to adopt legislative changes and adequate notice to providers and beneficiaries. During the transition period there should be no disallowances imposed by the federal government.

Congress should set any limits on the rates of growth in federal funding at a higher percentage in years one and two than in the subsequent years in order to achieve the target federal savings.

The federal government should allocate additional funds, independent of the general state allocation, to support start-up costs, such as information systems revisions, during the transition period.

Because states will likely be operating multiple systems during the transition period, there should be no penalties, sanctions, or other liabilities associated with the implementation of the new system.

Tribal Funds

The federal government should have full financial responsibility for, and provide adequate funding directly to tribal entities.

Enactment Date

States must be allowed to start program changes prior to the effective date of reduced federal financial participation.

Policy Recommendations Applicable to Block Grants

Transfer of Funds Between Block Grants

States should be given the flexibility to transfer within a given year, funds between and among different block grants.

State Maintenance of Effort

States should not be subject to any maintenance of effort requirements under a federal block grant.

Unspent Block Grant Funds

States should be permitted to carry forward unspent block grant funds from one year to the next.

Adopted by the National Council of State Human Service Administrators on July 7, 1995.

STEPS REQUIRED TO MAKE A SIGNIFICANT CHANGE IN A STATE MEDICAID PROGRAM

Making a significant change in a state Medicaid program—such as revising reimbursement policies, or eligibility, or covered services—cannot happen quickly. The following timeline shows the steps typically required to alter the state's program. Most of these steps are dictated by sound administrative practices or state laws and regulations, not merely federal requirements. While the total amount of time needed from conception of the change to its actual implementation will vary depending upon magnitude of the revision and the extent to which the state legislature must be involved, a change is unlikely to be effected in less than six months in any state.

INITIAL STEPS: RESEARCH AND PROGRAM DEVELOPMENT

Research:

- State and federal legislation
- Similar programs in other states
- Medicare, if applicable
- Impact on other state programs, if applicable
- Meet with industry representatives
- Meet with consumer groups
- Explore with state Medicaid advisory committee
- Solicit information/input from other Medicaid agency staff

If a change in covered services:

- Develop definition of benefits and any limitations
- Assess impact on other programs
- Determine which providers are qualified to render the service
- Determine licensure, certification, special training requirements
- Assess budget impact

If a change in eligible recipients:

- Develop projections of number of eligibles and extent of utilization (may require outside actuarial assistance)
- Assess budget impact

Payment methodology (either for new service or to revise existing payment policy)

- Determine how providers will be paid—fee schedule, per diem, etc. Establish fees (may require outside actuarial assistance)
- Assess budget impact

LEGISLATIVE/REGULATORY CHANGES AND PUBLIC NOTICE REQUIREMENTS

Legislature

- Propose changes to applicable committee of state legislature
- Testify at hearings
- Window of time may be limited, depending on when legislature is in session.

Submit State Plan Changes (2-3 months prior to implementation):

- Submit State Plan Amendment to Health Care Financing Administration (HCFA) regional of rice. Amend all other sections of plan affected by program change.
- Respond to questions from regional office.

State Regulation:

- If necessary, file a state regulation and/or amend other existing state regulations.

Public Notice (usually required at least 30 days prior to implementation, depending on state law)

- Place announcements in newspapers
- Hold field hearings in affected areas if required by state law

IMPLEMENTATION (EXTERNAL)

Provider/recipient notification (depending on nature of change):

- Write detailed provider manual draft; circulate for staff input; rewrite, circulate until final copy is approved. Write recipient notice and circulate for comment. Send to all recipients with Medicaid card.
- Write provider bulletins to notify other interested provider groups.
- Print messages on Provider Remittance Advices to educate providers about new program.
- Coordinate with provider associations as appropriate
- Develop provider agreement
- Develop provider enrollment packet; write letter regarding qualifications and documentation requirements.

IMPLEMENTATION (INTERNAL)

Information systems changes:

- Establish new provider types, provider specialties, types of service, level of care, etc.
- Update systems reporting requirements to include the new program
- Establish new audits and edits for the program. Write/edit audit resolution pages
- Modify existing audits/edits
- Develop and submit mock claim data and review to test system changes before implementation. It is important to detect any negative import in an existing computer program which may result from an edit/audit change.
- Amend fiscal agent contract scope of work (if necessary)

Billing:

- Determine how providers will bill; i.e. HCFA-1500, UB-82, or other special claim form Determine what attachments are required (i.e., medical necessity, plan of care) or develop new forms if needed

Coordination:

- Coordinate all facets of the program with fiscal agent, other state agencies, other departments of Medicaid agency (Third Party Liability, Medicare Unit,
- Provider Enrollment, MMIS, Managed Health Care, etc.)
- Provide advice and assistance to Provider Enrollment in enrolling providers. It may be necessary to establish a committee to review applications for approval/ denial.
- If program is being developed in cooperation with another state agency, write an interagency agreement

Contracting:

- Develop request for proposal, review bids, select winning contractor. This step might be required if change envisions use of private companies for quality assurance or consumer education or if agency is expanding use of managed care.

Training:

- Develop a training packet; train Provider Relations, Recipient Services, and other staff as needed
- Develop training packet for providers and assist in providing training as needed
- Train staff on information systems alterations

Quality Assurance:

- The program may require a complete Quality Assurance component, i.e., case management or outpatient psychiatric rehabilitation.
- Implement program
- Review and monitor program after implementation to insure it is running correctly and smoothly.

PREPARED STATEMENT OF HON. LAWTON CHILES

I want to thank the Committee for inviting me to testify today.

I have been very impressed with the individual and collective knowledge base on health care of this Committee over the past few years. I am especially glad that Florida now has a seat on this Committee in the able person of Bob Graham.

It has been a little over a year since I last spoke before this Committee. Then, as now, we were talking about reining in the spiralling cost of health care. There was broad consensus that in order to control costs you had to expand access. The debate was whether you would have "universal coverage" or only 95% coverage.

What a difference a year makes:

- Today there are more uninsured than there were last year;
- Health care coverage is more out of reach for many businesses and families; but now,
- We're talking about how much to *reduce* coverage.

And we've been told that there is a magic potion out there that solves this problem of rising health care costs—block grants.

On the surface, the concept of block grants sounds fine—more flexibility and more power shifted to the states. That flexibility has been a priority of my administration and it is the reason I pursued and received approval for the largest Medicaid waiver demonstration ever granted.

But what does "flexibility" mean? Will there really be fewer mandates? And, how will these dramatic reductions affect individual recipients, providers and states?

You have the toughest job. The Budget Committee has given you your destination—$182 billion reduction—and expects you to overcome all the hazards, potholes and huge risks to get there. You have to draw the map—this Committee's directions are going to be critical to the provision of health care in this country. I just hope all of the consequences are realized before the ink is dry.

I know some of my colleagues from other states have their maps drawn and mounted. They say they can manage their programs for less money. I agree with them. We can achieve real savings. A number of states have already proven they can generate savings by better managing their programs. We have been generating millions of dollars in savings to the federal government for several years now.

But some in Congress are desperately trying to tie Democrats—particularly governors—to the status quo. Nothing could be further from the truth. Governor Dean and I have both experienced the agonies and the ecstasies of obtaining a waiver from HCFA. We did so to dramatically change the programs in our states. We are committed to reform and I believe our track records bear us out.

I'm proud of the fact that Florida leads the nation in reforming Medicaid—

- We've cut the rate of growth by more than 50% and achieved real savings through managed care of Medicaid;
- We've imposed stringent price level controls on providers;
- We've encouraged alternatives to expensive long term care; and
- We've continued to use conservative standards for eligibility.

These approaches are creating significant savings today.

Florida already has more than 655,000 people or 40% of Medicaid eligibles enrolled in managed care. By next year we expect to have over one million of the state's 1.6 million eligibles enrolled. Only six other states have a higher percentage of their Medicaid recipients enrolled in managed care.

We have done much to control costs, eligibility, and benefits. And we've saved the state and federal government money while doing so. Between 1991 and 1992, Florida's average spending per recipient *actually declined* 3% while there was a nearly 8% *increase* nationally. Our cost per recipient was under $2,400 in 1993, that ranked us 44th in the nation.

But let's be sensible. We *cannot* achieve a 20% reduction in spending in this program without affecting coverage. And let's not forget who we are covering.

Medicaid is the vital life support system for our most vulnerable citizens. While most think it's mainly for poor welfare families, the fact is that two-thirds of Medicaid funds are spent on the elderly and disabled.

In Florida our fastest growing Medicaid population is people over the age of 85. They are also typically the most expensive population to serve. Middle-class families in America have become familiar with Medicaid when they seek care for parents who need home health or nursing home care.

Those middle-class families are facing the health care crisis today. And, for them, Medicaid is often the only way they can provide care for their elderly parents-in-need when the sky-rocketing nursing home bills come due.

So you can see why I am more than a little interested in how these block grants might be drawn and what flexibility I'll have to administer them.

I, like many of my colleagues here today, believe the states should have more flexibility to pursue managed care for our Medicaid population and to negotiate with our providers.

These efficiencies are important. And, I know they are supported by a broad bipartisan group of governors. But they *will not* make up for nearly the amount that the Congress is looking to *cut* out of Medicaid.

In fact, the Congressional Budget Office told the House last week that managed care reforms and repeal of the "Boren Amendment" would only save about $5 billion over 7 years. Remember, you've been instructed to cut $182 billion. So what additional flexibility would be required to make up for the remainder? I think part of the answer depends on how funds under the program are distributed.

If, as some of my colleagues have suggested, we change the formula from an entitlement that is need-based to a block grant with the same growth rate for every state, there will be dramatic inequities.

Some states, by their own admission, will actually receive a windfall. The flexibility they get will only add to their ability to cut the program and use those dollars for other purposes.

Other states, like Florida, Texas, California and Illinois and Utah I might add, will be in a far different place. Because of overall population growth and the aging of our citizens, we know our states will face higher growth in this program for the next 7 years. So while flexibility is providing real savings for some of our friends in other states it will be providing significant cutbacks in others.

Is that the kind of state flexibility this Committee is thinking about when it discusses block grants?

- The flexibility to shift billions in costs to local governments and the private sector?
- The flexibility to deny services?
- The flexibility to cut people off the program?

If it is, I think we should have an honest debate about the implications of that policy for working people in our states who are struggling to afford coverage and the small business owners who find it more and more difficult to provide coverage. We should debate the impact these cuts will have on services to seniors, the disabled, and kids.

But we should not pretend that we can manage these levels of cuts by making our programs more efficient. The Kaiser Commission on the Future of Medicaid estimates that nationwide, nearly 3 million people will lose coverage in 2002 alone. Florida would see more than 300,000 cut off the program. That's a *conservative* estimate, assuming that states have flexibility and are able to hold growth per person to no more than the inflation rate.

Your own CBO has already made that point, saying that, *"improving efficiency by itself almost certainly could not achieve reductions in the rate of growth of the order of magnitude being discussed. Some combination of cutbacks in eligibility. covered services. or payments to providers would probably be necessary."* CBO Testimony before House Commerce Subcommittee on Health and the Environment, June 21, 1995.

And we should also recognize that because this is a free country and people are free to move from state-to state as they please that some states will face growth pressures they are not able to control.

Even under the most conservative scenarios, Florida's Medicaid program is estimated to grow between 10–12% per year over the next seven years.

These increases reflect a growing and aging population. Some of these characteristics are currently unique to Florida but many states will be facing them in the future:

- Florida has the largest percentage of elderly people in the nation;
- The percentage of our uninsured is increasing. More than 20% of our non-elderly citizens have no health insurance;
- We have the second highest poverty rate (nearly 18%) among the large states; AND
- Florida is a destination not only for thousands of migrants from other countries, but also from other states, particularly during periods of recessions. Many of these new arrivals require health, economic and other financial assistance from the state. When you factor in the certainty of recessions, the pressure on state budgets builds.

Medicaid caseloads, that is the number of people on the program, typically peak about a year after a recession hits in Florida. In the year following our last recession, in the early 1990s we saw *caseload increases* of more than 25%.

No amount of state flexibility can fully remedy that situation.

Clearly, a proposal that ignores growth factors in the individual states would be disastrous. And, a proposal without adequate federal standards would be equally disastrous.

I hope that this subcommittee would not endorse a proposal to let a state use federal Medicaid dollars for non-health purposes—especially when some states will be receiving far less than they'll need to meet the needs of the elderly, disabled, and kids. You'll be sending federal funds for the Medicaid program to one state that will have the ability to divert those funds over to other programs while states like Florida, Texas and California will be cutting thousands off our Medicaid program.

I think you've seen the results of that kind of gimmickry in the Disproportionate Share program.

I hope you will keep in mind three critical questions as you restructure the Medicaid program:

1. Does the program treat citizens in each of our states fairly with an equitable distribution formula, or does it favor some states over others?
2. Does the program reward those states making a real commitment to reform and improved management, or does it lock in the inefficiencies of the past and turn back the clock on reform? AND
3. Does the program set and maintain an appropriate, basic national standard for the care of children and others in need, or does it establish a new underclass in America?

Florida stands ready to share in the cuts—and we have already gone a long way to reduce our Medicaid costs.

Now, I think the overall level of cuts proposed in the Budget Resolution are too high. And I think we'll have a disagreement over that. But, if you do need to cut $182 billion out of this program you should at least do it equitably.

I have a proposal to distribute these cuts fairly. It requires sacrifice for all states. It's a plan that would apply the cut fairly to *all* states.

For years, Congress has been told by the General Accounting Office that funds in the Medicaid program are not targeted to areas of true need.

The dollars, very simply, should go where the needy live. As the Congress looks at capping the program, it should account for the differences in population growth, poverty, uninsured rates and the percentage of elderly and disabled in each state. I am not alone in sharing that view.

Governor Wilson of California, Governor Symington of Arizona and others have expressed strong concerns about a block grant formula that does not take these factors into account.

The United States was founded upon the simple but unwavering belief that "all people are created equal." That basic principle is undermined—and on the verge of being abandoned—through a block grant proposal that values people differently.

Let me end by putting it simply: The debate in Congress should not be about developing a Michigan block grant, a Massachusetts block grant or a Florida block grant.

We should be talking, instead, about a true federal-state partnership for health care.

With a true federal-state partnership, a child, or a family in Florida, is worth as much as a child and a family anywhere else in the USA.

Any proposal leaving Washington must recognize that truth.

I want a program that enables me to address the particular needs and growth of Florida.

I want a program that allows me to continue the reforms that show great promise for *care*—as well as savings.

A true federal-state partnership for health care is one that has flexibility but it also recognizes the federal government's responsibility as a contributing partner.

Richard Nixon championed this approach as much as Ronald Reagan. Both argued that the federal government must share the fiscal burden and ensure equal treatment of those in need.

The states are willing to share the load. But, we want the federal government to cooperate—the way a partner should.

Thank you.

Prepared Statement of Hon. Howard Dean, M.D.

Good morning Mr. Chairman and members of the committee. I appreciate the opportunity to appear before you today to discuss one of the most important social issues to face Congress this session—restructuring the Medicaid program. While I am here today as a Democratic Governor and will express views consistent with that role, also, I am Chairman of the National Governors' Association (NGA), and I would like to take just a few minutes to discuss the position of the NGA on the task before you.

Let me make clear that the NGA has taken no position on any Congressional proposals to block grant the Medicaid program. NGA is a consensus-based organization and currently, there are differences among the membership on this complex issue. Governors are in complete agreement on one important fact—we oppose limits on federal expenditures if the current program structure is kept intact. That would result in potentially one of the greatest unfunded mandates in recent history.

Irrespective of any consideration of block grants, there are important areas in the program where states could be given more flexibility.

Allow States Greater Flexibility in Managed Care. Although the private sector is moving aggressively toward networks of care, the Medicaid program continues to require states, in almost all cases, to apply for a waiver from fee-for-service care in order to enroll beneficiaries in such networks. At recent count, 43 states have some form of managed care in their programs. Yet, states must submit waiver applications and apply for waiver renewals every two years. Moreover, states are limited in their ability to establish networks of care in geographic locations with large Medicaid populations because federal statutes prohibit Medicaid beneficiaries from being served in health maintenance organizations where more than 75 percent of the enrollees are Medicaid beneficiaries. This statutory requirement was thought to assure quality in such HMOs, but there has been no evidence that this proxy has ever worked.

If the nation is serious about controlling health care costs, it is essential to give states the opportunity to establish networks in Medicaid (including fully and partially capitated systems) through the regular plan amendment process.

Give Greater Leeway in Containing the Cost of Hospital and Long-Term Care Through the Boren Amendment. We believe that any coherent approach to Medicaid reform must address the inflexible provider reimbursement standards of the Boren Amendment. Simply put, we support repeal of the Boren Amendment. In addition to the provision's inflexibility, the Boren Amendment is much less relevant to hospital rates today since states are negotiating directly with hospitals less and more frequently with health care networks for more comprehensive health care packages that include hospital care. With regard to nursing homes, we urge Congress to consider alternatives that give states the relief and flexibility they need.

Promote Cost Control and Efficiency. States must be given the opportunity to explore alternative strategies for provider payment methods. Though Medicare and most private payers have moved away from cost-based reimbursement, federal legislation has mandated that certain providers be paid on the basis of costs. Mandatory "reasonable cost" reimbursement should be repealed.

Assume Full Financial Responsibility for All Low-Income Medicare Beneficiaries who are not otherwise Medicaid Eligible. Sine the passage of the Medicare catastrophic legislation in 1988, the federal government has increasingly passed on to the states, the responsibility to protect low-income Medicare beneficiaries. (e.g. the Qualified Medicare Beneficiaries Program). Medicare is a federal program and the federal government has the responsibility to assume all of the costs.

Reconsider the Nursing Home Reform Mandates in the Omnibus Budget Reconciliation Act of 1987. Congress mandated extensive new quality assurance measures for the Medicaid nursing home program in 1987 that allows the federal government to micro-manage state nursing home programs. States must be given more flexibility to administer their programs efficiently. Toward that end, Congress should repeal the Preadmission Screening and Annual Resident Review (PASARR) requirements. PASARR has been extremely cost inefficient, and states have developed other strategies to assure the appropriate placement of individuals with disabilities. In addition, the specialized annual resident review for mental illness and mental retardation is duplicative of existing annual review processes.

Allow Greater Flexibility in Medicaid Home- and Community-Based Care Programs. Home- and community-based care (HCBC) programs are an important alternative to institutional care for frail elderly and persons with disabilities. There are more than 100 different HCBC programs across the nation, and each state has at least one program. Existing Medicaid statutes have a programmatic bias toward institutional care therefore, states are required to use the waiver process to establish such programs. Statutes must be revised to give states the authority to establish these programs through a plan amendment process; however, states must be retain the authority to limit the number of individuals who could enroll for such care.

Mr. Chairman and members of the committee, differences of opinion remain among Governors on whether the individual entitlement to care should be broken, the nature of a block grant, and future funding for the program. I am sure that each of us will be talking with you directly before this debate concludes. However, I feel confident saying that all Governors are in agreement that this program cannot be sustained in its current form and significant changes must be made. Federal prescriptions must be eliminated or at least minimized, and the trend toward federal micro-management must be reversed.

The National Governors' Association, as a bipartisan organization, has a history of working with Congress and the administration in the development of sound and enduring public policy.

In that spirit, and on behalf of the Association, Mr. Chairman, we are committed and ready to work with you to achieve this most important goal—improving the Medicaid program.

PREPARED STATEMENT OF HON. JIM EDGAR

Mr. Chairman and members of this committee, I appreciate the opportunity to testify today and I look forward to working with you in the weeks ahead.

I think we all realize that, working together, we must overhaul Medicaid. There is really no alternative. The Medicaid program is outdated and out of control. Its mushrooming cost has caused huge problems in state budgets across this nation. And it is obvious that corralling this runaway expenditure is a major component of balancing the federal budget.

The leadership of this Congress wants to significantly slow the growth of Medicaid. I and other Governors are prepared to do our part. In fact, we are eager to bring this budget buster under control. Medicaid accounted for 10 percent of total spending by state governments in 1987. Today it consumes twice that.

But if we are to help balance the federal budget as well as balance our own budgets, we must have the flexibility and freedom that block grants would provide—flexibility to determine how we can best provide health care to the truly needy in our states, freedom from federal micromanagement, and freedom from the Boren

Amendment and other federal restraints that undercut us when we sit down to negotiate with providers.

Federal micromanagement has made it virtually impossible to control Medicaid costs. In Illinois, the tab for recent federal mandates topped 480 million dollars this year. Because of those mandates and rising health care costs, we increased spending for Medicaid between 1991 and 1993 more than we were able to boost funding for education, child welfare, prisons, mental health and law enforcement *combined.* That's right, more for Medicaid than for all of those other vital, worthwhile programs and services combined.

We are now spending more than 6 billion dollars annually on Medicaid in Illinois—64 times what we spent in 1966, the first year of the program!

This is not a partisan matter. Republican and Democratic governors alike have been grappling with this failed system. If we want to depart from the one-size-fits-all approach to Medicaid, we must go hat in hand to federal bureaucrats. They delay and delay on our waiver requests. And they are very reluctant, very reluctant to surrender control.

You have given us the responsibility to manage Medicaid. Now give us the flexibility and the freedom to do it well.

I'm confident all of us agree on the goal: Cost-effective health care for the truly needy—especially pregnant women and children. I would be amazed if any Governor has made children anything less than a top priority. I know this Governor has put them at the top of his list—and not only in the Medicaid area. Since 1991 we've increased funding for programs to address child abuse and neglect by 140 percent. We've increased funding for elementary and secondary education by more than half a billion dollars. We've given tremendous support and high visibility to programs to make sure kids are getting immunized and are being screened for lead poisoning. We've done all this while eliminating or cutting back dozens and dozens of programs in which needy children are not the primary beneficiaries.

I'm sure Governor after Governor would provide the same testimony. As I said, I don't think there's much of a quarrel over goals. But the crux of revamping Medicaid is changing how we try to reach those goals. The federal government has dictated benefits that are far more generous than those normally provided to working men and women through private insurance programs. Under the current Medicaid system, states cannot limit access to health care providers as a means to negotiate the best rates possible.

Give us the flexibility to determine what benefits are fair and reasonable in our individual states. Give us the freedom that virtually every private insurer has to limit the choice of providers under Preferred Provider arrangements or Managed Care plans. The states should be able to operate like any large insurer and negotiate the best rates with only the number of providers necessary to deliver the service. And we should be able to negotiate those rates free of the threat of lawsuits posed by the Boren amendment.

Block grants will give us the flexibility and freedom we seek so we can help those all of us want to help in the most cost-effective manner. Working together, we can overhaul Medicaid. I am sensitive to the concerns of governors who worry about whether block grants will reflect changing populations and other factors. It will not be easy to deal with issues such as the fairest way to distribute funds. But I believe we can develop an approach that is fair to all the states—as well as to recipients and taxpayers alike.

Clearly, the taxpayers of this nation cannot afford to pay the skyrocketing cost of a broken system. And, thus, it ultimately will fail the needy who rely on it for benefits. Massive reform has been long overdue. It needs to happen now. And we, as governors, look forward to working with you to make it happen.

PREPARED STATEMENT OF HON. ORRIN G. HATCH

Thank you Mr. Chairman.

I want to welcome the distinguished panel of Governors who have been gracious with their time to travel to Washington and share their views on Medicaid reform.

It is a personal pleasure and honor for me to welcome the distinguished Governor of Utah and my good friend, Michael Leavitt, to the hearing today.

Governor Leavitt has been in the vanguard of Medicaid reform and, through his efforts, has exemplified what can be done at the state level to promote program efficiency as well as maintain a level of quality care and services for Medicaid recipients.

As the current Chairman of the Republican Governors Association and a member of that organization's Medicaid Task Force, Governor Leavitt has been one of the principal architects in designing new and innovative proposals for reforming the existing Medicaid program.

As he points out in his testimony, "the philosophy of Utah has been to foster market place competition and individual recipient financial responsibility to the extent permitted by Federal law. This has allowed Utah to achieve one of the most efficient and actuarially sound Medicaid systems in the country."

Mr. Chairman, if we are going to truly reform Medicaid then we need the advice and expertise of the people who have been on the front line in administering this program—and those people are our nation's governors.

The Medicaid program now helps to pay the medical bills of 34 million Americans at a combined Federal and State costs of $144 billion in Fiscal Year 1994. Federal spending on Medicaid will grow at an annual rate of 10.4 percent over the next seven years according to the Congressional Budget Office. These levels are simply unsustainable in light of the present budgetary constraints facing both state and the Federal governments.

I welcome these hearings on Medicaid reform. I think it is particularly appropriate that Governor Chiles, Governor Dean, Governor Edgar and Governor Leavitt are our first witnesses. They have certainly distinguished themselves as key players in the national debate over Medicaid reform.

Once again, let me thank each of you for taking the time from your busy schedules to be with us today and I look forward to your testimony.

Prepared Statement of Sheldon L. Goldberg

INTRODUCTION

Mr. Chairman and Members of the Committee, I am Sheldon L. Goldberg, President of the American Association of Homes and Services for the Aging (AAHSA). I appreciate the opportunity to appear before the Senate Finance Committee today to share with you our hopes and concerns regarding the future of Medicaid, the federal program that provides long-term care for nearly four million older Americans.

AAHSA represents not-for-profit organizations dedicated to providing high-quality health care, housing and services to the nation's elderly. Our membership consists of nearly 5000 not-for-profit nursing homes, continuing care retirement communities, senior housing facilities, assisted living and community services. With our broad scope of facilities and services, AAHSA serves more than one million older persons each day. Consequently, we have a long history and significant experience in meeting the needs of the elderly and the important role the federal Medicaid program has played in ensuring that the needs of this population are adequately met.

I do not need to tell the Members of the Committee what you already know and with which you are struggling . . . that the nation is at a critical juncture in developing health care policy and that the decisions Congress makes in the next few months will impact the health and well being of millions of Americans for years to come.

Medicaid is both a health policy and a promise. The Medicaid program, as it currently exists, illustrates a particular health policy that promises to provide health care for many who cannot otherwise afford it and to provide long-term care to those without other resources to pay for long-term care.

We are very concerned with proposed changes in the Medicaid program that would, in our view, constitute rationing of care to the elderly. Turning the current Medicaid program into a capped block grant program with little or no federal oversight will relegate all Medicaid beneficiaries to second class citizenship when it comes to access to quality health care.

I want to focus on the role of Medicaid in providing long term care for the nation's elderly and why changes to this program, while perhaps necessary, should be made slowly and cautiously due to the nature of the aging population and the limited reliable information available regarding realizing additional cost savings from the Medicaid program.

The elderly are the fastest growing segment of the population and this trend is expected to continue at an accelerated rate as those born within the baby boom years begin to age. While the overall elderly population is growing, a subsection of that population—those over 85 years of age—is growing at a similar rate, meaning that the nation will not only have more elderly individuals to care for, but that they will be older and sicker.

In 1989, health care expenditures for persons 65 years of age and older was three and a half times greater than that for persons 19 to 64 years old. One percent of health care users consume 30 percent of all health care resources, and half of these users are the elderly. In 1993, Medicaid spent 36 percent of its resources on the elderly although they comprised only 12 percent of enrollees. Current estimates indicate that $56.4 billion or 30 percent of total Medicaid dollars in 1996 will help to pay for long term care for nearly 4 million frail elderly.

Medicaid is the source of payment for nearly half of all long term care within nursing homes. It is the only federal and public source of continued long term care. Though Medicare provides a long-term care benefit for nursing facility and home health services, it is provided only under limited circumstances and, for nursing facility care, only for a brief period of time. Medicaid, however, is the payer of choice, by necessity, for a substantial amount of long term care. The other payment alternatives are private long-term care insurance or personal financial resources. Both of these options are currently available only to a small segment of the elderly population due to the economic demographics of this population.

To perform radical surgery on Medicaid by converting the program into capped block grants with little or no federal oversight will take from many elderly individuals the only resource available to them for much needed long term care. Medicaid is not an extravagant program in terms of both state and federal expenditures. To further reduce either benefits or provider payments means to deny care to those who are most vulnerable and most in need of care.

PROPOSED MEDICAID BLOCK GRANTS

Congress is proposing to save $180 billion in Medicaid funds over seven years by totally eliminating the federal Medicaid program and all individual entitlements to health-care services for the indigent. Current plans call for giving the responsibility back to the states in the form of block grants, with no strings.

According to a study by the Long-Term Care Campaign, a five percent spending cap could result in $37 billion in cuts to long-term care services over the next five years, with 1.75 million people denied access to nursing facility care.

AAHSA is gravely concerned about this proposal, and we urge you to oppose block grants. We view block grants as a federal abdication of responsibility for the health of frail elderly Americans who can no longer care for themselves. It constitutes balancing the budget on the backs of those who can bear it the least.

We have several specific concerns about block grants:

- Block grants would end the federal entitlement to Medicaid benefits based on age, disability, and poverty. States would receive a fixed sum which would not necessarily reflect increased demand for health care services. If block grant funds were exhausted, states would either have to use their own funds to meet health care needs or turn away those seeking coverage.
- The elimination of the individual entitlement could lead to competition between population groups over the allocation of health care money under a block grant. Children and the frail elderly would be competing for shrinking financial resources.
- While no specific language has been developed on block grant formulas, the chairman of the House Budget Committee, Rep. John Kasich (R-OH), has said that he favors giving the money to states with virtually no strings attached. This proposal could mean, for example, that states would not even be required to use the federal block grant funds for medical care. Instead, states could spend the money on roads, prisons, or other state functions.

A pure block grant also would not require states to maintain their present levels of spending on health care for the indigent. Thus states could simply take federal dollars and use them to totally replace any state spending on health care for the poor.

- States that have experienced rapid growth in their Medicaid populations or that have expanded eligibility for Medicaid under a waiver would be the hardest hit by limited federal block grants. In all likelihood, the amount of their block grant would reflect their past spending under the program, not the growth in the number of people eligible for coverage.
- States in which income levels are lower than the national average could also be placed at a disadvantage, since they would have to spend proportionately more of their own funds to make up for the reduction in federal spending than would states where incomes are higher. Thus adverse economic conditions in a state, such as an increase in unemployment, would result in yet further damage to the state economy by increasing demand for indigent health care for which no federal matching funds would be available.

The potential impact of block grants cannot be underestimated. In the final analysis, we will see denial of care to those who are most vulnerable, dollars being spent inappropriately, the wholesale movement of the Medicaid population into managed care programs without adequate information regarding appropriate managed care models for long-term care. Additionally, innovation developed to date by states may be discouraged, if not actually punished by providing less to those states that are already attempting to do more with less. While we support efforts to provide states with more flexibility in delivering health care to the Medicaid population through waivers and demonstrations, our overarching concern is quality health care for the elderly. The commitment to quality health care is in direct conflict with the potential consequences of transforming the Medicaid program into a block grant. For that reason, AAHSA strongly opposes current Congressional proposals to shift responsibility for this important program to the states.

PAYMENT/REIMBURSEMENT/REGULATIONS

Ultimately, the risk presented by turning Medicaid into a block grant is that states could pay providers anything as reimbursement for services without any relation to the actual cost of providing services.

Unfortunately, its seems that Congress is assuming that there is a method to reduce the costs of Medicaid without compromising quality or access. For example, repealing the Boren amendment as a method to reduce cost will contravene efforts to date to do exactly what the Boren amendment requires: to ensure that nursing facility reimbursement incorporate costs that provide care in a efficient and effective manner. Boren attempts to ensure quality care and cost efficiency. To repeal the amendment guarantees neither continued quality nor increased cost efficiency and the likely outcome will be diminished access, compromised quality and ultimately no true cost savings because the consequences will be borne by the American public.

It is a popular and often incorporated cost saving strategy to reduce payments to providers under the false assumption that the big and anonymous provider can absorb the reduction in payments due to the inevitable excess that providers allegedly enjoy. This, Mr. Chairman is a myth.

Medicaid payments to providers are already significantly lower than those in the private sector. There is evidence that Medicaid beneficiaries currently experience limited access to services because of low provider payment rates. Additional cuts to provider payments would reduce Medicaid beneficiaries' already limited health care access as the number and quality of providers willing to serve Medicaid patients would further decline.

Reduction in payments to providers would likely eviscerate the improvements in the quality of care that have been made in the last few years, and doom the promise of the nursing facility reform amendments of OBRA 1987 to ensure that all nursing facility residents receive services to help meet their highest practicable physical, mental, and psychological well-being.

While demanding that providers do more with less for a growing and more chronically ill population, our members are further constrained in their efforts to apply their limited resources to the delivery of quality care by the overabundance of regulations with which they must comply. It is absolutely imperative that nursing facility residents and employees be assured of a safe and high quality environment and that standards exist to ensure that this is accomplished. However, a significant amount of time and money is directed toward compliance with regulations having questionable benefit to the residents. Some of these resources could be better applied to the provision of enhanced care or care to more individuals. Given the tension between regulatory compliance and doing more with less for residents, we feel that nursing facility regulations should be reassessed for their relative costs and benefits. This is completely congruent with Senator Dole's recommended risk/benefit analysis included in S 343, and we commend him for his recognition of this conflict.

Mr. Chairman, I must elaborate on the points just mentioned concerning the Boren amendment, cutting payments to providers and increasingly onerous regulations. I represent organizations that provide services to frail and vulnerable elderly individuals because it is their mission, not because it is a financial investment. My members endeavor to provide the highest quality of care to all, but my nursing facility members are currently losing an average of $10.00 to $15.00 per day on every Medicaid resident for whom they care. Our goal is not to make a profit on our residents; we do no have to return dividends to stockholders. But even for not-for-profit providers, there is only a limited period of time in which they can subsidize inadequate Medicaid payments or shift costs to those residents who are paying for care out of their own pockets.

To cope with further reductions in payments, above what many states have already implemented, nursing facilities would have to reduce the quality of services or reduce the number of indigent persons for whom they care . . . . or, most likely, both.

We are cognizant of the importance of reducing Federal expenditures while preserving access and quality. One approach is to enact tax clarifications to support the purchase of private long-term care insurance. Greater financing of long-term care needs through long-term care insurance could significantly reduce Medicaid expenditures, while preserving scarce public resources for those most in need. The House has included such provisions in HR 1215, and we hope that there will be companion legislation within the Senate.

Tax incentives to foster the purchase of private long-term care insurance by individuals who can afford it should be accompanied by minimal federal standards for such policies, not only as a means of enhancing consumer protection but also of promoting market stability and reducing cost.. Another desirable incentive to reduce Medicaid expenditures through promotion of long-term care insurance would be to allow expansion of the creative public-private partnership projects that are currently underway in four states. Those projects, originally funded by the Robert Wood Johnson Foundation, were designed to make quality long-term care insurance more affordable. Individuals who purchase these policies, that are required to meet rigid consumer protection standards, may protect part or all of their life savings in the event that they need long-term care. An amendment in OBRA 1993 limited the development of these promising partnership programs, and we believe that amendment should be repealed. Senator Cohen's S 423 includes such language. We urge this Committee to consider legislation that provides both incentives and protections for purchasers of long term care insurance

MANAGED CARE

Most proposals for reducing Medicare and Medicaid costs entail increased reliance on managed care. We believe that managed care is, indeed, the wave of the future, and can be very effective in offering a wider range of services to beneficiaries. We do, however, offer a few cautions about the role of managed care in serving frail elderly individuals.

First of all, it should be noted that managed care has been most effective in reducing spending on acute care. Aside from the types of demonstration projects, managed care remains largely an unknown as applied to long-term care populations. It is not at all clear that applying acute care managed care principles to long-term care will yield the cost savings for which so many hope.

Some managed care organizations have been marketing their regular, non-long-term care products to residents in our facilities. We have received many complaints from our members that residents in their facilities, including housing, assisted living, continuing care retirement communities and nursing facilities, are recruited by HMOs and signed up for membership without ever fully understanding the limitations such membership may impose on them, particularly in terms of restriction of provider choice. Residents often do not understand that they are trading choice of provider for additional benefits.

When residents discover the restrictions on choice of provider, they often drop out of the HMO. Based on our discussions with the Health Care Financing Administration, we do not believe that they are tracking HMO disenrollment in a uniform manner that would provide meaningful information about the prevalence of this problem. We suggest that you use your influence with HCFA to ensure that disenrollment data is gathered to monitor this serious problem.

The issue of misunderstanding limitations on choice of providers is particularly troublesome to residents of continuing care retirement communities (CCRCs) throughout the country. Those senior citizens have signed contracts for life care services, in the expectation that all needed long-term care services would be provided on the CCRC campus that they call home. When those residents sign up for Medicare coverage through a HMO, most do not realize that the HMO will not pay for the skilled nursing facility care available to them through the retirement community in which they live. Instead, residents are often discharged from the hospital and shipped across town to a different nursing facility rather than the nursing facility attached to their CCRC. We recommend a change in law governing managed care organizations, to require managed car organizations to contract with continuing care retirement communities for relevant Medicare services if those communities are willing to accept the managed care organization's reimbursement rate for similar services and goods, and to abide by other managed car organization requirements.

Another major issue we have encountered regarding the interface of long-term care and managed care is the clash between the conservative utilization review incentives inherent in managed care and the responsibilities imposed on nursing facilities. Nursing facilities are the only health care providers in America who have a statutory and regulatory responsibility to ensure that a patient improves if that is in any way possible. We are charged with providing services to meet the "highest practicable physical, mental, and psychological well-being" of every resident. Failure to meet that requirement can result in exclusion from Medicare and Medicaid and fines of up to $10,000 per day. This affirmative responsibility requires maximum provision of services and therapies in order to promote and enhance well-being, but that often conflicts with the "minimalist" approach of HMOs. we ask that Congress reaffirm its statutory commitment to the highest practicable well-being of nursing facility residents by confirming in committee report language the obligation of managed care organizations to abide by nursing facility reform requirements in their coverage of Medicare nursing facility services.

There is some evidence that costs can be reduced without compromising quality within certain demonstration projects such as the Program of All Inclusive Care for the Elderly (PACE) program, 1115 and 1119 waivers and some social HMOs. Currently, most managed care plans are focused primarily on the Medicare package of services that emphasizes primary and acute care needs, while largely ignoring chronic illness and long-term care. Comprehensive managed care demonstration projects such as PACE, are potential excellent examples of managed care that integrate acute and long-term care.

These programs work to integrate acute, primary and long-term care, to provide a comprehensive array of services to very frail, nursing facility eligible populations on a capitated basis. The programs demonstrate a response to the increasing awareness of the need to bridge the acute and primary care sectors with the long term care sector.

AAHSA believes that there needs to be further fostering of chronic care network models such as PACE and social HMOs. We thank Senator Dole for his vision in support of PACE projects, evidenced by S 990, which expands the number of PACE programs in the United States. Not only will care improve, but cost savings will occur. The current care fragmentation that occurs with a patient over the course of time and many providers simply adds excess costs to the system. We believe that these programs, which are already saving federal and state dollars, will demonstrate the way to more effectively integrate acute and long-term care funding into a true continuum of services that can best meet the needs of frail elderly individuals. Application of a continuum of care will optimally meet the needs of the long term care patient while also providing the best opportunity for cost containment within long term care.

HOME AND COMMUNITY SERVICES

In recent years, Medicaid has increasingly help meet the health and assistance needs of the older individual by covering home and community based services through the waivers granted under the Social Security Act, Sections 1115 and 1915(c). These waiver programs allow states the flexibility to determine the best use of their funds in providing for the home and community based needs of their elders, people with disabilities and other state-targeted population groups.

Home and community-based services play a vital role in the long-term care continuum of services. These services encompass a wide array of medical, social, personal and supportive services to assist the older individuals who have lost some capacity for self-care because of chronic illness or condition. With support from community services, older persons are better able to remain independent in their own homes as long as possible.

Without such funding, elderly individuals may have no recourse but to seek nursing facility care, thus, ultimately driving up overall health care costs at great sacrifice of personal autonomy. Ironically, it is many of those states that have made the most use of these innovative waivers in the past several years that stand to lose the most under Medicaid block grants.

While AAHSA supports a federal oversight role for Medicaid, we also urge continued state flexibility in developing waivers under either section 1115 or 1915. The President's budget proposal augments the delivery of home and community-based services to individuals with limitations in their activities of daily living. We, too, are committed to continued and enhanced availability of home and community based services, but with an overriding emphasis that ensures that services be provided in the most cost-effective setting—be that in the home, the community, or in a congregate living facility or a nursing facility.

SUMMARY

Mr. Chairman, you are charged with achieving vast spending cuts and, at the same time, protecting the basic health and well-being of America's most frail and vulnerable individuals. You have a daunting task before you. I hope my comments have given pause to consider the many ramifications of converting Medicaid to a capped block grant program. Such a transformation promises to limit access to quality long term care services for our nation's elderly. The Medicaid program means too much for too many vulnerable people to be subject to revision without sufficient time and safeguards.

Reducing payments to providers, while ignoring the cost of onerous and superfluous regulations, will place enormous burdens on residents, providers and family members. Movement into managed care without sufficient consumer education for the elderly population or data regarding cost effectiveness of managed care for long term care may result in significant disenrollment and cost increases, not savings. We are pleased with the current opportunities providing states with increased flexibility with federal oversight through granting waivers, the PACE program and social HMOs. This combined approach of state flexibility with federal oversight will yield the information necessary to determine how the Medicaid program can best be further modified to provide access and savings.

Mr. Chairman, when I have talked to senior citizens in this country about aging, a frequent refrain has been, "I am not afraid of dying, but I am afraid of growing old—of becoming sick and dependent, of losing my friends and family, of losing my dignity as a person." My members provide services to help allay those concerns, and to care for those individuals when they can no longer care for themselves. We all need your help, however, as you consider sweeping changes in the programs that support these elderly Americans in their last years.

I thank you again for the opportunity to join in these important discussions. I pledge to work with you in any way possible to control health care spending and reduce the national deficit while still preserving access to high quality long-term care services for our nation's elderly.

PREPARED STATEMENT OF GREGG HAIFLEY

My name is Gregg Haifley and I am the Senior Health Associate at the Children's Defense Fund. The Maternal and Child Health Coalition, of which CDF is a member, thanks you for inviting us to testify today on the national Medicaid health safety net for children and pregnant women, which now pays for the health care of one in four children and one and three infants in America. I am testifying on behalf of the many state and national groups that have agreed to the principles on the Medicaid program attached to our testimony.

The Maternal and Child Health Coalition itself is composed of fifty national organizations for whom maternal and child health is a significant priority. Members include provider groups such as the American Academy of Pediatrics and the National Association of Children's Hospitals; advocacy organizations representing children with disabilities and their families, such as Family Voices and The Arc; state and local government organizations such as the National Association of Counties, the Association of Maternal and Child Health Programs, and the National Association of County and City Health Officials; and advocates of maternal and child health such as the March of Dimes Birth Defects Foundation, Child Welfare League of America, Catholic Charities USA, U.S. Catholic Conference, the Women's Legal Defense Fund, and the American Public Health Association.

The maternal and child health community has a very simple message to convey today. As you consider reform of the Medicaid program, we believe it is essential to preserve certain critical features for children and pregnant women—minimum national standards for children's and pregnant women's eligibility, benefits, and access to appropriate care. Attached as Appendix A[1] is a set of recommendations endorsed by one-hundred and fifty organizations on the importance of preserving Medicaid's basic eligibility and benefits provisions for low-income children and pregnant women as well as a statement by thirteen national organizations of pediatric health care providers.

It is essential to maintain the guaranteed federal floor for eligibility, coverage of prenatal and preventive care, and medically necessary services, and access to appropriate care for children and pregnant women. This is sound policy for maternal and child health, but it is also sound policy for future national health, productivity and economic growth.

Previous Congresses have taken a bipartisan approach to shaping Medicaid policy with an important priority on the health of children and pregnant women. That approach continued this year with the maternal and child health Medicaid provision adopted unanimously by the Senate Budget Committee for inclusion in the budget resolution. This provision had bipartisan co-sponsorship, including the co-sponsorship of Senator Grassley. It emphasizes that the health care needs of low-income pregnant women and children should be a top priority in any restructuring of Medicaid. We applaud Senator Grassley, as well as the other co-sponsors, for taking the lead in ensuring that maternal and child health remain a critical focus during Medicaid reform. Our recommendations to preserve guaranteed coverage and access to medically necessary pediatric and obstetrical services would preserve those best Medicaid features that have developed out of this bipartisan approach.

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[1] The appendix to Mr. Haifley's statement was made a part of the official files of the committee.

ELIGIBILITY

Let me first discuss eligibility. Medicaid has covered welfare recipients since its beginnings in 1965. But, because of eligibility expansions in the 1980s and early 1990s, developed in part because of high infant mortality rates and other negative child health indicators, Medicaid has increasingly become an essential source of health care coverage for children and pregnant women in low-wage working families. Today, among the children of all ages covered by Medicaid, more than half live in working families. Of the 1.4 million infants (babies up to age one) covered by Medicaid in 1993, 70 percent were from working families and did not receive AFDC cash assistance. While this program is essential for families receiving welfare, it also provides health care for a broad band of poor and near-poor working American families.

In covering more children and pregnant women, Medicaid played a crucial role in offsetting, in part, the long-term trend of declining employment-based coverage for dependents. Without these Medicaid expansions, there would certainly have been millions more uninsured children. Between 1977 and 1987, the percentage of children with employer-based insurance declined from 72.8 percent to 62.9 percent. (This pace of private disinsurance continued at roughly the same pace in the late 1980s and early 1990s.) Between 1977 and 1987, the proportion of children who lacked insurance for all or part of the year increased from 17.5 percent to 23 percent.

The 1989 Congressional enactment of Medicaid eligibility expansions for children and pregnant women (requiring coverage of pregnant women and children under age six with family income up to 133 percent of poverty and certain older children—those born after September 30, 1983—up to 100 percent of poverty, and allowing coverage to higher income levels if states choose) has led to Medicaid coverage for 3 million additional children and pregnant women in low-wage working families.

Medicaid now covers nearly one-third of the births in this country and covers more than 17 million children overall—one in four children. Even while private insurance coverage was dropping, the proportion of pregnant women who were uninsured fell from 11 percent to 7 percent between 1988 and 1994 because of expanded Medicaid coverage. Given the long-term trend of steadily eroding private health insurance, it is imperative to preserve the national Medicaid safety net for pregnant women and children, including the ongoing phase-in of older children from working poor families. Doing otherwise could add significantly to the numbers of uninsured children and pregnant women.

The need to preserve the safety net of continued guaranteed eligibility for children and pregnant women deserves heightened attention in light of The Kaiser Commission on the Future of Medicaid's recent report "The Impact of the House and Senate Budget Committees' Proposals on Medicaid Expenditures." That study projects that the Congressional budget resolution targets for Medicaid spending would require eliminating coverage for as many as 5.8 million adults and children in families. This Kaiser Commission projection assumes that controls on spending through managed care, reductions in covered services, and cuts in provider payments would be implemented prior to cutting beneficiaries from the program.

MEDICALLY NECESSARY CARE

Second, it is essential to maintain Medicaid's existing coverage of the benefits pregnant women and children need, including prenatal care, preventive care, and medically necessary care—the scope of coverage which is of particular importance to children with chronic conditions or disabilities, but is important to all children. The Early and Periodic Screening, Diagnosis and Treatment services—the benefits component of the Medicaid program for children—must be preserved. "EPSDT" ensures that screenings, prevention, and the full range of medically necessary services are available. This national commitment to children makes complete medical sense and is eminently affordable. There is no concept of state flexibility that would make rational the coverage of speech therapy or essential prescription drugs or hearing aids for school children in South Dakota, New Jersey or Louisiana, but not in North Dakota, New York or Florida.

Covering this full range of necessary services is remarkably inexpensive. Children represent more than half of all Medicaid beneficiaries. However, even with many of America's most disabled children in the program, on average children's care is much less expensive than that for adults. Payments for maternity and infant care through the first year of life represent less than 7 percent of total Medicaid expenditures. Children account for only one-quarter of all Medicaid payments for services. Payments on behalf of children and pregnant women accounted for only 11 percent of the growth in Medicaid spending between 1988 and 1991. In 1993, the average Medicaid expenditure for a covered child under age 21 was $1,065. The Medicaid expenditure per elderly adult that year was $7,590. Attached as Appendix B[1] are fact sheets with coverage, expenditure, uncompensated hospital delivery costs, and infant mortality statistics.

This does not mean that there should not be greater state flexibility in operating the program, nor that considerable federal savings in the cost of the program could not be achieved over the next several years. State flexibility for the delivery of care through managed care, if carefully structured and monitored, could move toward these goals. This committee should act to ensure, however, that children and pregnant women realize improved access to and quality of care, not a deterioration. We believe that Senator Chafee's S. 839, for example, makes important strides to strike a balance between protecting children's and pregnant women's health under the Medicaid program while granting states considerable flexibility and protecting providers from burdensome regulation.

We want to emphasize that "outcome measures" can not substitute for basic eligibility and services criteria or for standards for managed care. First, there are very few measures for pediatric health care in the managed care context. They consist of rates of childhood immunization at age two, hospitalization for asthma and rate of low birthweight births. While these measures are fine for certain narrow purposes, they tell very little about the range of childhood disorders. Moreover, the immunization measure commonly used is for children enrolled in a plan from birth to age two—few Medicaid children go from birth to age two in one plan with continuous eligibility. Outcomes measures for early prenatal care typically look at the initiation of prenatal care within the first trimester for women enrolled in plans for the twelve month period prior to delivery. Pregnant women covered by the Medicaid program, particularly those women who become eligible based in part on their pregnancy, will not meet the twelve month enrollment criteria for being included in the outcomes sample.

BLOCK GRANTS

Some governors have testified before this committee seeking total state flexibility, through a Medicaid block grant, to determine eligibility and benefits, while projecting that they would continue to cover children and pregnant women at current eligibility levels. Maternal and child health advocates appreciate their commitments. However, we have two concerns. First, the major strategy for achieving Medicaid savings is managed care. However, managed care has been largely untried for the services required by the elderly and disabled, who account for 70 percent of Medicaid spending. States will be forced to seek additional ways to save, including changes in eligibility and coverage, which disproportionately affect children. Second, we know historically that many states have moved to cover children and pregnant women only when minimal national standards were put in place. For example, when the federal minimum eligibility level for young children and pregnant women went to its current level, roughly two-thirds of the states had to act to meet that level, despite having had the option to do so prior to the enactment of that federal floor. Recent comments by the Director of the Missouri Department of Social Services serve to underscore our point. He predicted that low-income children and pregnant women would bear the brunt of cuts, including cuts of prenatal and preventive care, since it would be politically impossible in his state to cut eligibility or services for the disabled and elderly. Children and pregnant women would be the targets for cuts because ". . . compared to the political clout of the elderly and disabled, that's where we'd have to go . . . ."

CO-PAYMENTS

Finally, we want to emphasize the need to waive co-payments on children's services or keep such co-payments nominal. In a 1993 report titled "Benefit Design: Patient Cost-Sharing," the Office of Technology Assessment (OTA) reviewed cost-sharing studies and noted that, when there is no cost-sharing, there is increased use of pediatric preventive services. OTA said this finding justifies having no cost-sharing when prevention is a policy goal. We urge the Committee to specifically exclude preventive services from any cost-sharing requirements. OTA also noted that research demonstrated the disparate impact that cost-sharing had on utilization of necessary services for children in low-income families and that special protection relating to cost-sharing for children in families with income less than 200 percent of poverty may be necessary to ensure access to care.

CONCLUSION

The maternal and child health community looks forward to further discussions with the Committee as you develop proposals to reform the Medicaid program. As you seek to secure savings from the program and allow greater state flexibility, it will be critical that you also continue to provide the ensured coverage, benefits and access essential for low-income children and pregnant women.

Prepared Statement of Robert E. Hurley, Ph.D.

My name is Robert Hurley and I am a faculty member at the Medical College of Virginia/Virginia Commonwealth University in Richmond. I welcome the opportunity to share observations regarding the 1915b waiver experience this morning. I have spent much of the last 11 years examining the growth and evolution of Medicaid managed care across the country and much of what we know about this development has come via the use of the 1915b waiver authority.

The waiver authority has enabled the states and HCFA to accumulate substantial, diverse experience with many forms of managed care. The flexibility extended to states has permitted them to develop several alternative approaches to adapting managed care models to serve Medicaid beneficiaries. 1915b waiver applications have typically requested relief from several requirements, but the most common feature waived has been freedom of choice of provider. This has permitted beneficiaries to be mandatorily enrolled with primary care case managers or gatekeepers, or in health maintenance organizations (HMO) or other prepaid health plans.

The range of variation has been enormous, not inconsistent with the intent to promote creativity and ingenuity. States have also engaged in a great deal of shared learning from the waiver experience; thereby contributing to what has been an inexorable growth toward managed care, everywhere, at least for the AFDC and AFDC related portion of the Medicaid program.

HCFA has orchestrated and modulated this waiver process by enforcing a kind of “first do no harm” oversight role, whereby states have to demonstrate that there is not harm done either budget-wise or beneficiary-wise. Budgetarily, states must demonstrate that managed care programs do not result in increased costs. Beneficiary-wise, they must demonstrate that prior levels of access and quality are not compromised. HCFA has required states to have periodic external assessments or evaluations to determine if the programs succeeded in both of these ways, as a condition for waiver renewal.

We have conducted some of these assessments and reviewed many more including a number of them as part of a study for HCFA. The results suggest that credible savings ranging from 5 to 15 percent in these programs can be documented without adverse access or quality consequences. In truth however, the 1915b waiver studies are not especially strong methodologically, as states are mainly intent on proving savings have been achieved to assure waivers are renewed. I mention this to contrast these studies with the 1115 research and demonstration waiver evaluations which are far more rigorous and reliable.

Despite our extensive knowledge about the 1915b experience, I suggest that we should be cautious in extrapolating from it at this point in time. The revolutionary changes occurring in the health care market place are profoundly affecting Medicaid today. These changes are creating historic opportunities for state agencies to use beneficiary lives for leverage in their negotiations with managed care plans to obtain price and service concessions heretofore viewed as unattainable. Thus, we really are into uncharted, albeit quite promising territory for 1915b waivered managed care programs.

Let me give you three examples. In many metropolitan markets several well-established HMOs are either bidding and/or competing to enroll Medicaid beneficiaries for the first time because Medicaid represents an attractive and underdeveloped market for them. In some mature markets where enrollment has been occurring, states are receiving renewal bids that are equal to or less than bid prices of the previous year—a phenomenon becoming common in the private sector that may also be available to prudent purchasing Medicaid agencies. And finally, we have in a number of markets established managed care plans paying rates to their network providers that are the same for both commercial and Medicaid enrollees in the plans, thereby achieving both mainstreaming and payment parity—two of the most elusive long-term goals of the Medicaid program.

But I would be remiss if I did not share some notes of caution. First, most of our experience in Medicaid managed care under 1915b waivers has been with the AFDC population. We do not yet know with certainty whether enrollment of the aged, blind and disabled in managed care on a mandatory basis is administratively feasible, clinically suitable, or economically desirable. Arizona is the only state which has yet to both do this and to have it carefully evaluated. There are many reasons why what we know from the AFDC population experience in managed care cannot be generalized to the rest of the Medicaid beneficiaries who consume the preponderance of program expenditures.

The second caveat deals with the impact of rapidly expanding mandatory managed care on safety net providers, meaning those who provide a substantial amount of the care to uninsured individuals. These providers are finding it extremely challenging to make themselves attractive to and viable in managed care networks. But even if they succeed in doing so, they will be hard pressed to obtain payment rates that produce surpluses needed to cross-subsidize services to the uninsured, as they have done in the past. Unless states find ways to cover the uninsured to enable them to participate in managed care programs—as only very few have yet done—I believe we will precipitate a crisis situation in the not-too-distant future ,where there will not be enough safety net providers capable of serving the uninsured in many urban areas.

My final concern relates to where the locus of beneficiary protection will be if the oversight or stewardship role of HCFA is greatly diminished. I say this because there is currently extreme variation among states in their capacity and capability to develop the prudent purchasing competence needed to meet beneficiary needs in a managed care world. I worry that if we too rapidly shift financial risk to beleaguered and overmatched states, the “first do no harm” dictum may only be applied to the budgetary concern of living within the constraint of no additional state expenditures. In a block granted environment, for example, it is hard to see what agencies within state government will have sufficient independence to vigorously and vigilantly promote beneficiary protection.

Thank you for the opportunity to address you this morning and I will be glad to respond to questions at the appropriate time.

Prepared Statement of Richard C. Ladd

Long-term care represents a major portion of Medicaid expenditures. According to Medicaid statistics from the Health Care Financing Administration for Fiscal Year 1993, long-term care accounted for about 40 percent of all Medicaid spending. The largest user group of long-term care services are those over the age of 75 years. This group accounts for about 9 percent of of all Medicaid recipients, but about 24.9 percent of all Medicaid expenditures. This testimony will be limited to mostly the elderly and physically disabled populations, however the recommendations for this group could also apply to other long-term care populations, such as the developmentally disabled.

A recent (as yet unpublished) study by the University of Minnesota, and Ladd and Associates has been completed for all state long-term care expenditures for fiscal year 1992. This study is a compilation of data received mostly from the Health Care Financing Administration and the Administration on Aging. The study was funded as part of a grant from the Administration on Aging. Much of the data in this testimony will come from this study. This study shows a wide variation between states on the amount of Medicaid dollars spent on long-term care, and how those dollars are spent.

The study shows that in 1992 about 28.3 billion dollars was spent on Medicaid long-term care for the elderly and physically disabled. About 84 percent of this expenditure went to nursing homes and about 16 percent went to home and community based care programs. Pennsylvania had the highest nursing home percentage at 99.07%, and Oregon had the lowest at 52.5%. About 2 billion dollars in non-Medicaid funds were spent by the states in 1992 on long-term care programs for the elderly and physically disabled. If these non-Medicaid dollars are added, the highest state spending percentage on nursing home was Mississippi at 95.6%, and the lowest was again Oregon at 49.6%.

The study also showed that the amount of total dollars spent on long-term care per person over the age of 65 years varied greatly between states. New York spent the most at $2,719.84 and Arizona spent the least at about $348.85. The average was $896.26 (Oregon spent $732.88).

The study concluded that the state of Oregon has the most progressive long-term care system in the United States, and that the District of Columbia is the least progressive. The basis for this conclusion is how committed the state is to providing the kind of care, that study after study has shown those in risk of long-term care prefer. This often stated preference is home and community based care.

The percentage of Medicaid long-term care expenditures on home and community based care is currently about 17 percent nationally. This percentage has been increasing at about one (1) percent per year for the last several years. At this rate, it will take 33 years for the country as a whole to reach the level currently existing in Oregon, and there are some who think the current level in Oregon is still too high.

The obvious public policy questions that should be asked, given this data are: "should states provide more balanced long-term care systems that are closer to user preference?," "what is needed to provide such a system?," and "will such a system cost additional money?." The answer to the first question, in my opinion, is yes, states should provide more balanced long-term care systems. The answer to the last question is obvious from the data: Oregon has the system most attune to the wishes of the users of long-term care, and spends less on these services (on a per-capita basis) than the national average.

The answer to the second question (what is needed?) is harder and probably has more disagreement. States know how to set up more balanced, user friendly long-term care systems. Home and community based waivers have now been in existence for nearly 14 years. States have used these waivers to establish a wide range of effective home and community based services. For the most part these services delay or prevent admissions to nursing homes, and are preferred by long-term care users. However, only a very few states have used these waivers to lower substantially their dependence on nursing homes.

While it is true that for a period of time the federal government was reluctant to issue or renew home and community based waivers, this changed with the Bush administration, and has been given even more flexibility under the current administration. Home and community base waivers are not hard to obtain today. When I was Commissioner of Health and Human Services in Texas in 1993, we received approval for a 22,000 person waiver in only three months.

Most states have not used this additional waiver flexibility to any great degree. Making home and community based waivers more flexible will help, but I doubt it will cause states to move much more quickly to establish more balanced long-term care systems. Making home and community based services an optional Medicaid service, would eliminate the drudgery of submitting waivers, but I am of the opinion that it would not increase substantially the number of home and community based services.

The basic problem for states is the protected status of nursing homes. Nursing homes are protected by being an entitlement service with no federal limit on the number of Medicaid nursing home beds a state has. Home and community based waiver services, on the other hand, are not an entitlement services and the federal government limits the number of persons a state may serve. Nursing homes are also protected by the Boren Amendment (governing how nursing homes and hospitals will be reimbursed). If states accept Medicaid, they must have a nursing home program, but they need not have a waiver program. The protected status of nursing homes has made it harder, though not impossible, to move toward more balanced long-term care systems. Eliminating the protected status of nursing homes would be of great value to the states.

Making home and community based services an optional Medicaid program and ending the protected status of nursing homes would be positive actions from the states' point of view. Unfortunately, these actions would most likely still not be enough to make most states move toward establishing more balanced long-term care systems.

Over the years, I have talked to virtually all of the people who operate the long-term care systems in the 50 states. I have also visited, gave speeches, and assisted 27 of these states in their long-term care programs. The most common theme generated by this experience is that states do not move aggressively to balance their long-term care systems because of the very powerful influence on state legislatures by the nursing home industry. In Texas, for example, the 22,000 person approved waiver was only allowed to implement services for 3,000 persons. This was primarily due to the pressure instituted by the nursing home industry, during a two hour meeting in the Lieutenant Governor's office.

There is not much Congress can do by amending current Medicaid laws that will eliminate this influence on state legislatures. The only answer for most states, in my opinion, is that the placement decisions for long-term care services must be removed from political influence. These decisions should be made solely on the basis of client need and the cost of providing the services.

Many states are already moving in this direction for the acute care portion of Medicaid by setting up Managed Care Plans. These plans save the states money because they tend to use hospitals much less and out-patient clinics much more, and emergency rooms much less and doctor's offices much more. Managed care plans are capitated and only make money if they spend less than the money they receive under the capitation. For this reason they will almost always choose the provider that can get the job done for the least expense. They are, for the most part, immune to the political pressures of the health care industry.

Managed Care Plans for long-term care services should operate very much like such plans for acute services. Because these plans are capitated, they will, for economic reasons, choose the provider that can meet the clients needs for the least cost. For most of the people needing long-term care services this provider will be home and community based services, not nursing home services. Oregon, for example, in 1994 served only 22.7 percent of its long-term care clients in nursing homes. The state of Minnesota has just received approval for a 1115 waiver to allow it to set up Managed Care Plans for long-term care. This will be the first large scale test of this concept.

The best solution for the federal government would be to grant more flexibility to states, and to encourage Managed Care Plans for long-term care services. This could be done by either block granting Medicaid, or by amending current Medicaid laws. In either case, Medicaid should be divided into two programs: Acute services, and Long-Term Care services. If Medicaid is block granted, expenditure reporting requirements should be retained, and transfers between the two block grants should be limited to prevent some states from reducing long-term care populations in order to maintain acute services (or vice versa).

The Medicaid program could then be capped at a fixed inflation level (perhaps the 4.6 percent per year in the Senate budget), and states given three years to implement Managed Care Plans for both Acute services and Long-Term Care services. If after three years, a state has implemented such plans, the inflation rate would be changed to reflect two factors: the growth of the populations at risk of using these services, and the closest inflation factor that reflects actual inflation for these services. If states have not implemented Managed Care Plans, the fixed inflation rate could be reduced one (1) percentage point, until such plans are implemented.

An exception to these requirements should be granted to any state that serves less than 35 percent of its long-term care clients in nursing homes. Such states could be considered to have already implemented more balanced, user friendly long-term care systems. These states should not be required to implement Managed Care Plans, and should be allowed annual increases based on population growth and actual inflation.

Finally, the federal government should retain some quality assurance laws to prevent Managed Care Plans from providing less than appropriate services to save money.

I believe these actions would encourage states to develop more balanced, more user friendly long-term care services. These services would come much closer to meeting wishes of the users, and would limit growth to more defined levels.

PREPARED STATEMENT OF HON. MICHAEL O. LEAVITT

It is a privilege for me to come before this distinguished body to address two very important questions pertaining to your Medicaid deliberations. First, what is the best strategy for maximizing Medicaid's critical role in providing access to health care? Second, how do we slow the rate of growth in Medicaid expenditures without simply transferring this unsustainable liability to the states?

States have been charged with the primary responsibility to administer Medicaid since its inception in 1965. During the last thirty years, we have moved responsibly to look for ways to achieve both program and administrative cost savings, while assuring delivery of quality health care. While each state has met with varying degrees of success in achieving this goal, the evidence is quite clear that taken as a whole, the states have done a good job of serving the country's poor, unborn, disabled, aged, blind and medically at-risk citizens. This has been done in the face of heavy federal regulation and federal restrictions that have severely hampered state efforts.

In Utah specifically, Medicaid serves 1 out of every 8 Utahns each year. The philosophy of the State has been to foster market place competition and individual recipient financial responsibility to the extent permitted by federal law. This has allowed us to achieve one of the most efficient and actuarially sound Medicaid systems in the country. In fact, sound management of Medicaid has contributed in large measure to the State being consistently selected as one of America's best managed states by Financial World. Utah has been employed competitive purchasing of major Medicaid services since 1981. We first included HMO products in the Medicaid program in 1982. Along this vein, the State long ago abandoned inflationary cost based reimbursement systems except where still required by present Medicaid federal law.

Shortly after taking office in 1993, I joined with my Utah legislative colleagues in a non-partisan initiative that would span 8 years of comprehensive, incremental health care reform that would ultimately make available affordable health care to all Utahns by the year 2000. This bold yet down to earth strategy is set forth in a document titled HEALTHPRINT—A BLUEPRINT FOR MARKET BASED REFORM IN UTAH. A major component of HEALTHPRINT is expansion of Medicaid to more Utahns living at or near poverty using no more federal dollars than would actuarially have been spent under the traditional Medicaid program. Under the current system, the Medicaid piece of HEALTHPRINT would take the form of an 1115 Waiver.

Unfortunately, as a new governor and as a new student navigating the complex Medicaid federal approval processes, I have discovered that this country's governors do not have the authority needed to reinvent how this vital health care program can best meet the needs of its citizenry with the limited federal and state dollars that will be available in the future. Increasingly, federal mandates, court decisions and regulations issued by federal bureaucrats have tied the states' hands when it comes to tailoring a Medicaid program that fits within the budgetary and health care environments of the individual states.

The Medicaid program has evolved into a myriad of sub-programs each with its own set of individual entitlement rules. Administrative flexibility and simplicity has given way to unsurpassed administrative complexity and insensitivity to serving the public efficiently. In addition, federal administration of the Medicaid program through its various regional offices is not proceeding quickly enough to recognize the dramatic changes occurring in our health care markets. As a consequence, states with aggressive health reform efforts are stymied by out-of-date federal regulations and waiver application processes that not only fail to respond to the opportunities presenting themselves to states today, but establish artificial rules and conditions for granting waivers that have absolutely no bearing on the realities of the market place.

While there are many, many examples of how federal administration of Medicaid has failed to meet the needs of the states, its citizens and this country, I would like to recap just a few. First, we have the outdated Boren requirements that tie state reimbursement systems to obsolete cost-based methodologies rather than the competitive market trends evolving so rapidly in most of our markets. This will continue to cost the states and the federal government billions of dollars each year.

Next, we have the so called list of "optional" services that each state can supposedly add or subtract from its benefit package to stay within budgetary constraints. Unfortunately, federal law and regulation have restricted states from removing optional services from so many special sub-populations of Medicaid, that by the time all these protected eligibility groups are eliminated there is very little cost savings left to realize.

The current system prohibits states willing to make hard choices. An example. Currently, a Medicaid recipient has benefits that are 130% of the average worker in the private sector in our state. After expensive deliberation and discussion with low income advocates, we decided that in Utah we would rather have everybody have basic health care than fewer have the best health plan in the state. We proposed to reduce the benefit level from 130% of the average private sector plan to approximately 1 18%, using the savings to provide coverage to people who currently have no coverage. What we believe to be a common sense decision, was not allowed under the existing system. There may be those of you who still disagree with our decision, but if we are going to meet our objective of providing access to basic quality health care to all Utahns, we need the ability to make those hard decisions.

Another example, federal law and regulation has so tightly limited the use of copayments and other forms of financial responsibility within the Medicaid population that any strategies to save funds by sensitizing these participants to the consequences of health care utilization decisions is lost. Reasonable cost sharing requirements must be injected into the purchase of health care by a significant part of the Medicaid population, particularly adults, if we hope to gain control of this program and assure its continued availability to future generations.

In the administrative area, the explicit and expensive requirements imposed by federal law and regulation on operation of state Medicaid agencies inhibits redesign of the basic program to transfer greater responsibility to private health plans where they can be more cost-efficiently borne, and the basic responsibilities of states redefined around rate negotiation, health plan enrollment, quality of care monitoring and reporting, and health data collection and analysis.

There will shortly be no need for states to maintain expensive, complex Medicaid Management Information Systems. In fact, the State of Utah is presently operating on a trial basis a single, comprehensive medical billing system that electronically processes claims from all provider types. UHIN, the Utah Health Information Network, collects claims on behalf of all public and private insuring entities in Utah. UHIN is a non-profit organization that was formed voluntarily to address the growing concern around duplicate administrative expenses incurred by multiple insurers. UHIN receives claims either manually or electronically, processes them for payment against the requirements of each liable insurer, handles automatically the coordination of benefits where more than one insurer is involved, applies limitations and other edits against the services received, and directs a payment remittance statement back to the provider advising of the action taken on the claim, and the parties from whom payment will be received. All organizations that came together to form UHIN committed in the articles of incorporation to return all administrative savings that are derived from this public/private venture to the consumer.

UHIN is just one example of how the states are moving aggressively to implement real health care reform that will stand the test of time. The time for action is now, and the place for this action is the individual states.

As Congress looks toward limiting the federal funds available to the Medicaid program, it is vital the states be given the tools necessary to craft a program that is not only efficient, but which continues to provide at-risk populations good quality medical care. In my opinion, the most important tool the states must have to accomplish this is flexibility.

Franklin D. Roosevelt said "The future lies with those wise political leaders who realize that the great public is interested more in government than in politics." As the nation's governors, each of us has the first line responsibility to understand our communities needs and the values based on which those needs must be met. I hope we have the courage and the wisdom to give states the needed flexibility to make critical decisions relative to managing Medicaid within a mutually acceptable funding agreement. This is the only path I see that will enable us to both balance the federal budget and preserve this important program.

Again, it has been my pleasure and privilege to speak to you today, and at this time I would be very happy to speak to any specific questions or concerns you may have.

PREPARED STATEMENT OF NELDA MCCALL

Thank you for this opportunity to testify concerning Medicaid state flexibility. My remarks will focus on the Arizona Health Care Cost Containment System (AHCCCS). I have been the Project Director of two evaluations of AHCCCS for the Health Care Financing Administration (HCFA).

Arizona has never had a traditional Medicaid program. In 1982, it received an 1115 waiver from HCFA to operate AHCCCS, a capitated managed care program for the indigent in Arizona. The initial implementation did not include long-term care services. Long-term care was added to the program in 1989.

Currently the state, still operating under an 1115 waiver, provides services to approximately 450,000 beneficiaries. All Medicaid eligibility groups are covered including women and children and the elderly and disabled.

Approximately 430,000 are served in the acute care program and 20,000 in the long-term care program called the Arizona Long-Term Care System (ALTCS). The acute care program serves most of its beneficiaries through 13 health plans selected through a competitive bidding process. Beneficiaries have a choice of more than one plan in all of the Arizona counties.

The long-term care program capitates contractors to provide acute, home and community-based, and institutional services to approximately 20,000 beneficiaries determined by the state to be at risk of institutionalization. Contractors include five counties, two private contractors, and the Arizona Department of Economic Security. Beneficiaries are placed in home care or in nursing homes. Capitation payments are structured to provide incentives to serve eligibles in home care rather than in nursing homes.

Let me review some of the evaluation findings. In all analyses except the cost analysis the control group is New Mexico.

With respect to the utilization of medical care services both in the acute care and the long-term care program, Arizona beneficiaries had fewer hospital days, fewer procedures, and more evaluation and management services. Overall intensity of service use was similar, but the pattern of use showed a distribution de-emphasizing the use of institutional services and specialty care.

Two reviews of medical records were done. Findings of the review of children's and pregnant women's records three years after the start of the acute care program (in 1985) showed that care for children (well baby care, care for otitis media, immunizations) was in greater conformity with generally accepted American Academy of Pediatrics guidelines. With respect to maternity care, pregnancy care and pregnancy outcomes were similar but Arizona had a smaller number of prenatal visits and a later initiation of pregnancy care. Review of nursing home records of Arizona and New Mexico beneficiaries for care received in the second and third years of the long-term care program (1990 and 1991) indicated that quality was poorer on some measures for AHCCCS beneficiaries (incidence of pressure sores, incidence of fever, having a catheter inserted, having an influenza vaccination) and similar on other measures (incidence of falls and fractures, use of psychotropic drugs). Although these findings highlighted areas of concern, it is important to note that they are for early implementation periods. In addition, the problems identified were taken seriously by the AHCCCS administration, which has initiated steps to include assessments of the problem areas found in their ongoing quality assurance activities.

A household survey of acute care beneficiaries in 1985 found access to routine care better under AHCCCS, although beneficiaries reported more problems with access to emergency care. AHCCCS beneficiaries also indicated in significantly higher numbers that they have a place to go for care in the evenings and weekends. Their use of medical care for particular symptoms indicated that they seemed to be getting desirable levels of care given their reported symptoms. Primary prevention and preventative care use was similar. Satisfaction levels were also high. On seven elements of care, the lowest score received was "somewhat satisfied."

We followed new admissions to the long-term care program and found a much more coordinated system of care in Arizona which permitted transitions from home care to nursing homes and from nursing home to home care. These transitions would suggest a system of coordinated care providing more choice for consumers.

Evaluation of the cost effectiveness of home care provided under AHCCCS indicates that attempts to limit spending on long-term care by diverting clients from institutional to home care settings have been successful. This is in stark contrast to previous evaluations of home and community-based care programs which have found home care to be a complement to institutional care, not a substitute.

Administrative costs of a "managed" care program are likely to be greater than a traditional program. A "managed" Medicaid program requires the development of infrastructure not part of a traditional program. This includes systems for procuring providers, monitoring service networks, enrolling members with plans, making capitation payments, regulating plan activities (both in terms of quality assurance and financial viability), and collecting and analyzing encounter data.

Cost analysis of the AHCCCS and ALTCS programs indicate cost savings for the programs compared to a traditional program. The acute care program averaged savings of 7% per year over the first 11 years of the program (fiscal years 1983-1993). Cost savings would have been 11% per year if only medical service costs were considered. As mentioned above, higher than average administrative costs reduce the total cost savings to 7% per year. The long-term care program cost savings are estimated to be 17% per year over the second to fifth year of the program. Considering only medical services, cost savings would have been 18% per year in the long-term care program.

Based on my experience in evaluating AHCCCS it is clear that states can have good ideas and can do a good job in implementing innovative programs. This should help alleviate the concerns that some have about giving states flexibility in design, coverage, and reimbursement issues. However, states can be more effective—and can demonstrate their effectiveness more concretely— if there is federal involvement to insure accountability in the following areas:

- Standardizing reporting of utilization data and program costs.
- Technical assistance on issues of program implementation and quality assurance.
- Coordinating and funding research to assess what does and does not work.

- Providing a forum for the sharing of ideas among the states.

Prepared Statement of Stephen McConnell

Mr. Chairman and Members of the Committee. Thank you for inviting me here today to talk with you about the Medicaid program and its vital importance to millions of older Americans. I appear before you today wearing several hats—

as Chair of the Long Term Care Campaign, a broad coalition of 141 national organizations representing not only the elderly but people of all ages who need long term care because of chronic disease and disability;

as a member of the Leadership Council of Aging Organizations, a coalition of 41 national organizations concerned with the well-being of older Americans; and as senior vice president for public policy of the Alzheimer's Association, the national organization that speaks for the 4 million people who are living with Alzheimer's disease and struggling with overwhelming costs of care.

Mr. Chairman, you and your colleagues on the Finance Committee face the unenviable task of trying to find a way to achieve the spending targets set in the budget resolution without devastating programs that guarantee basic health and economic security for very vulnerable people. Nowhere will that task be more difficult than Medicaid. We hope that today's hearing is just the beginning of our work together over the next few months to try to fashion a response that will move us to real cost control without harming people and exacerbating problems in our health care system.

You asked me to focus on Medicaid and the elderly. I will do that. But I want to make clear that the Long Term Care Campaign, the Leadership Council of Aging Organizations, and the Alzheimer's Association are concerned about the entire Medicaid population. Nothing I say should be taken as suggesting that the interests of the elderly who need Medicaid for basic health security should be placed above those of poor women and children, or the nonelderly with disabilities. The last thing we should do is set up a situation that forces needy individuals and families to fight with each other over pieces of a shrinking Medicaid pie. That may be the inevitable result of the drastic spending cuts and block grant proposals now on the table.

Distinctions among "categories" of Medicaid beneficiaries are arbitrary and potentially dangerous. For example, the aging and disability communities overlap and share common concerns. The elderly need long term care because of their disabilities; people with disabilities are aging; disabling illnesses like Alzheimer's and Parkinson's—generally considered diseases of aging—are striking younger people as well.

People live in families, not age groups. And everyone in the family is affected by the birth of a child with a disability, a job loss that means the end of health insurance, a wage earner's spinal cord injury, or a grandparent's Alzheimer's disease. We are all in this together.

Speaking to the needs of elderly Medicaid beneficiaries, I would like to do three things this morning.

First, I will discuss the vital importance of Medicaid as a lifeline to health security for over 4 million older Americans, and the inextricable links between Medicaid and Medicare. The Finance Committee is the one place in Congress that can look at these programs together and we urge you to do so.

Then, I will make two points about the issues before the Committee today. The Medicaid reductions in the budget resolution are too drastic. And converting Medicaid to a block grant is an unwise and dangerous abdication of federal responsibility. There is no way to do either of these things without harming very vulnerable people.

Finally, I will offer a number of recommendations to maintain essential protections of Medicaid while working towards reasonable cost savings in the program.

MEDICAID IS THE VITAL INSURER OF LAST RESORT FOR OVER 4 MILLION OLDER AMERICANS

In 1995, Medicaid will provide the lifeline to health security for 4.3 million seniors. These are Medicare beneficiaries who are too poor to pay their out-of-pocket health care costs, middle class retirees who have used up their life savings to pay for long term care, and poor seniors who do not qualify for Medicare at all. 28% of all Medicaid dollars were spent on these elderly beneficiaries.

The largest part of Medicaid for seniors goes to help pay their long term care bills when they have exhausted their own resources. In 1995, more than one in three Medicaid dollars ($53.5 billion) will pay for long term care; two-thirds of the long term care beneficiaries were elderly. Medicaid pays more than half of the total nursing home bill in the United States. This is because neither Medicare nor private health insurance policies covers the type of "custodial" long term care most of the frail elderly need, and because annual nursing home bills that average $38,000 a year (and are much higher in many urban areas) quickly exhaust the life savings of most middle class families.

> *These are people like Elaine and Stewart Millon of Galesburg, Michigan. Stewart spent 17 years in a small law practice, then was ordained as a Lutheran minister and spent the next 25 years as a pastor. He and Elaine raised their children and accumulated savings for their retirement. But Stewart got Alzheimer's disease. Elaine cared for him at home as long as she could, but she became ill. When Stewart finally had to move to a nursing home, Medicare was no help because the kind of care he needed was considered "custodial." Elaine liquidated every asset they had—life insurance, savings, IRAs—and spent it to pay the bills, until she was down to the $17,000 Michigan allows her to keep under spousal impoverishment rules. Now, Elaine spends half of her remaining income on her share of the nursing home bill; Medicaid pays the balance. This leaves her with about $1200 a month to live on. The nursing home now costs $100 a day. Even if Elaine spent every penny she had left, she would not have enough to pay the bill without help from Medicaid.*

Medicaid also helps about 2 million poor and near-poor Medicare beneficiaries pay their out-of-pocket health care costs. In 1995, the average Medicare beneficiary will spend $2750 on health care, not including long term care. In 1995, the average costs of Medicare premiums and deductibles alone, for a beneficiary with one hospitalization, were $1369—almost one-fifth of a poverty-level income. Under the Qualified Medicare Beneficiary (QMB) Program, Medicaid pays the premiums, deductibles, and copayments for Medicare beneficiaries who have income below the poverty line ($7360 for a single person or $9340 for a couple in 1994), and premiums for beneficiaries with income below 120% of poverty.

> *These are people like Ethel Lawson, age 69, of Indianapolis whose only income is a monthly Social Security check of $569. She manages to stretch that money to pay her housing and utility expenses ($370), to keep up the car she needs to visit her sick son every day ($85), and for food and incidentals. The QMB program pays $46.10 for her monthly Medicare Part B premium, giving her basic health care coverage she could not otherwise afford. When she fell and dislocated her shoulder, it paid the $700 deductible for Medicare treatment of the injury—a payment she never could have made on her own.*

Low-income elderly who meet the state's Medicaid eligibility rules may also qualify for Medicaid, for benefits Medicare does not cover—like prescription drugs, preventive or rehabilitative services, hearing aids, dental care, or eyeglasses, or because they do not qualify for Medicare at all.

> *These are people like Mrs. Smith who worked in an assortment of low wage jobs—household domestic, elevator operator, cook at Blair House. Her small Social Security check leaves her with income far below the poverty line. She qualifies for Supplemental Security Income but she has not applied because she does not want to "take welfare." But now at the age of 90, she has complicated health problems resulting from a combination of diabetes, glaucoma, and high blood pressure. Medicaid is paying for the prescription drugs that manage her illnesses and the podiatry services that are critical because of her diabetes.*

The elderly who rely on Medicaid do not have options. Without these benefits, many would literally have to make impossible choices between food, shelter and health care. Their health problems are not going to go away, and they are not suddenly going to find hidden resources to pay their health bills. There are not any easy alternatives for meeting their health and long term care needs.

Private long term care insurance, for example, is suggested by some as an alternative to Medicaid for all but very low-income elderly. But even the most enthusiastic proponents of this product concede that it will never cover more than 40% of the elderly, primarily because of the cost of a good policy. Some put the number as low as 10%. And because of medical underwriting (a responsible practice insurers use to prevent adverse risk selection), almost no one who already has symptoms that suggest an eventual need for long term care can buy a policy, regardless of their income. Even if the industry is successful in its attempts to market long term care insurance to younger people and manage to maintain premium stability so that people can afford their policies over time, the impact of that coverage will not be seen until well into the next century as those insured begin to reach the ages where they are most likely to need long term care. Over the next 7 years (the life of the Budget Resolution), most elderly who will need long term care will have no option but to spend their own income and resources until they qualify for Medicaid—if the program is still there to help them.

MEDICAID AND MEDICARE ARE INEXTRICABLY LINKED—CONGRESS CANNOT MAKE DRASTIC CHANGES IN ONE WITHOUT AFFECTING THE OTHER

Low income and frail elderly rely on both Medicaid and Medicare to provide basic health security. Yet there is almost no attention being paid to the way in which cuts and changes in one program will affect the other. Let me give you two examples.

> If Medicare copayments or premiums are increased to save money in that program, the need for the Qualified Medicare Beneficiary (QMB) Program will increase accordingly. But if Medicaid spending is capped, it will be more difficult for states to meet their existing QMB responsibilities. Some have considered alleviating the burden on the states and protecting low income elderly by federalizing the QMB program, but that leaves unanswered questions about how the program would be financed.
>
> A block grant for Medicaid would drive a deeper wedge between acute and long term care, at a time when many are trying to encourage managed care for the elderly. But limiting the risk of managed care providers to that part of health care covered by Medicare, while leaving all of the risk for long term care in the hands of the state, could exacerbate the incentives for cost-shifting that already exist in the system. This could leave the elderly with chronic diseases like Alzheimer's at particular risk of being shuffled between doctors, hospitals, and nursing homes with no one responsible for their overall care and well-being.

On June 29th, the Majority Leader introduced the PACE Provider Act of 1995, to encourage programs that break down the distinctions between primary, acute, and long term care by providing comprehensive services on a capitated basis for very frail elderly people who are already eligible for nursing home care. According to Senator Dole, the existing PACE projects have reduced utilization of high-cost inpatient services, expanded community based long term care, and shown a 5 to 15 percent reduction in Medicare and Medicaid spending relative to a comparable frail population in the traditional separated Medicare and Medicaid systems.

Senator Dole's legislation would encourage expansion of such programs and establish a provider category for reimbursement under Title XVIII and Title XIX of the Social Security Act as well as private pay. Other Senators are exploring ways to encourage the development of even broader chronic care networks to coordinate and integrate these services and sources of payment. We agree with Senator Dole that this is a direction we need to explore fully. By block granting Medicaid and removing federal responsibility for long term care, we would be moving in exactly the opposite direction.

Managed care presents unique concerns for the elderly because of their complex health needs. But if we have any hope of making it work, especially for the frail elderly and people with chronic illness and disability, we need to find ways to put providers at risk for all of the care an individual needs instead of increasing incentives to shift the responsibility elsewhere. Until we do, we will encourage fragmented services, inefficiency, and waste. And we leave open the potential for fraud and abuse as vulnerable seniors are shunted back and forth between payers and providers, with no one assuming full responsibility. We still have a lot to learn about how to do this right, but it is a real opportunity that we cannot afford to abandon if we want to achieve real cost savings in health care for the elderly and the chronically ill.

THE $182 BILLION CUT IN MEDICAID SPENDING IS TOO BIG—IT CANNOT BE ACHIEVED WITHOUT HARMING LOW INCOME AND FRAIL ELDERLY

All of us would like to believe that it would be possible to achieve the savings in the Budget Resolution without harming people. But an honest look at the numbers makes it pretty clear that cannot be done. Under the Budget Resolution, the growth in Medicaid will be capped at 4% after 1998. This would mean that Medicaid spending would be reduced by almost 30% from its current projected level in 2002.

According to an analysis done by the Urban Institute for the Kaiser Commission on the Future of Medicaid, under current law Medicaid expenditures for the elderly will grow an average of 8.9% between 1994 and 2000 (from $37.8 billion in 1994 to $73.9 billion in 2002). If states were to absorb the cuts in the Budget Resolution equally across all eligibility groups, the Urban Institute estimates a reduction of from 429,000 to 928,000 elderly Medicaid beneficiaries who would have been eligible under current law in 2002.

An analysis of the impact on long term care alone, done by Lewin-VHI, paints an even grimmer picture. Looking particularly at the projected growth of home and community based long term care under current law, Lewin estimates that over 2 million elderly and persons with disabilities of all ages could lose their access to long term care. An earlier analysis of the impact of the House Budget Resolution suggested that 13 states (Alabama, Georgia, Hawaii, Indiana, Iowa, Louisiana, Mississippi, Nevada, North Carolina, Ohio, Pennsylvania, Tennessee, and Texas) could be forced to give up their home and community care programs altogether.

The impact on the QMB program is just as alarming. In 1994, the program was reaching about 40% of low income elderly eligible for assistance. States were already complaining about the cost of the program, and governors were urging a federal takeover. As mentioned earlier, if Congress increases Medicare cost-sharing to achieve the budget targets for that program, that will increase the need for assistance for low-income elderly and put additional pressures on the QMB program—pressures states are not likely to meet.

States will not have enough money to meet all of their current Medicaid obligations. And they will have only so many options to bring their spending within the limits Congress is attempting to impose. They can cut provider reimbursement. They can eliminate benefits. They can cut back eligibility. Whatever they do, it is the beneficiaries—the frailest, the sickest, the poorest—who will suffer.

A MEDICAID BLOCK GRANT WOULD REMOVE ESSENTIAL PROTECTIONS FOR THE MOST VULNERABLE ELDERLY

Medicaid is not perfect. But Congress will not solve the problems in the program by abdicating the federal role and sending the money out to the states in a block grant. It could just make matters worse.

A block grant implies the end of any individual entitlement to services. For the poor and frail elderly, this means the end of any guarantee of one last place to turn for help when they have no other way to meet extraordinary costs of health or long term care. Seniors like Elaine and Stewart Millon and Ethel Lawson never expected that after a lifetime of hard work and careful planning they would end up relying on a welfare program. But it has provided the final safety net when everything else was gone.

A block grant also means the end of federal protections that Congress, consumers, and providers have worked to build into Medicaid—nursing home standards, spousal impoverishment protections, the QMB program. The consequences would be severe.

> If spousal income protections disappear, we are setting the stage to return to the days when retired couples were forced to make horrendous choices when one of them entered a nursing home—either divorce after a lifetime of mutual commitment to protect some income for the spouse left at home, or give up the house and all income security for the spouse to pay the nursing home bill.
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> Without federal nursing home quality standards, we may see a move back to the time before enactment of the 1987 nursing home reform law, when many states abdicated any responsibility to assure quality. The progress that has been made to restore dignity and quality of life for nursing home residents, to end the misuse of physical and chemical restraints, to assure training for nursing home workers, will begin to erode.
>
> And the health security Medicare was intended to provide will mean little or nothing for those elderly who are too poor to pay their share of the costs. And it is local and county taxpayers who are likely to find themselves left paying for their uncompensated care.

Finally, a block grant jeopardizes promising efforts to improve health care for the frail elderly and chronically ill through coordinated and integrated care. If Congress is truly interested in achieving cost savings in health care for the elderly, without jeopardizing access or quality of care, then we have to find ways to bring the benefits we now provide under Medicare and Medicaid together—not sever the connections altogether.

RECOMMENDATIONS

We are prepared to work with you to try to improve Medicaid and reduce costs. Reductions of the magnitude proposed, however, will have a significant impact on coverage for millions of older Americans. We must be realistic about savings that can be achieved while protecting the vulnerable elderly who now have no other recourse than Medicaid to meet their basic health care needs, including long term care. The following key features of the Medicaid program are central to assuring those protections:

- The entitlement status of individuals under the Medicaid program should be maintained. We agree that costs should not be allowed to grow uncontrolled, but the program should be allowed to grow enough to accommodate increases in the numbers of people who will need assistance as well as the cost of providing that assistance.
- The joint federal-state responsibility for the program should be maintained, with clear mechanisms for federal oversight to assure that taxpayer funds are used for Medicaid purposes.
- States should be required to match federal funds they receive for Medicaid purposes.
- Populations currently covered by the Medicaid program should be protected. This includes low-income elderly who are eligible under the QMB program, as well as those of all ages who need long term care because of physical, cognitive, or mental impairments.
- Federal law should define minimum services the states must provide, including long term care in the home and community as well as in institutions.
- Congress should continue to encourage coordination and integration of care for the frail elderly and chronically ill. This is as important to the future of Medicare as it is to Medicaid.

With regard to long term care for the elderly, we have the following specific recommendations:

- Federal law should encourage a balanced long term care system that includes home and community care, as well as a range of residential care options in addition to nursing homes. (Home and community care includes but is not necessarily limited to personal assistance, respite, adult day care, homemaker and chore assistance and home health, with the transportation and support needed to utilize the services.) This has the potential for real cost savings in Medicaid long term care, for those who can live independently if they have appropriate services, and for those who have family who can care for them at home if they have enough help.

  In the case of a person with Alzheimer's disease, research shows that it is possible to provide care at home at a cost that is three and a half times less than the cost of care in a nursing home—$12,500 compared with $42,000. This is not because the person at home needs less care, but because at home families provide most of the care.
- Congress should specifically eliminate requirements of current law that tie eligibility for home and community care to nursing home care. To control their long term care expenditures, states are requiring higher levels of functional disability for nursing home care, but under current law, that has the perverse effect of denying home and community care to persons with lesser disability—even though such care could delay and in some cases prevent their eventual need for nursing home care.

  New research shows, for example, that a relatively inexpensive service like respite (a small amount of assistance to give a full-time family caregiver brief time to herself) can significantly delay the need for nursing home care—but only if it is provided early enough in the course of the disease to make a difference. Under current Medicaid law, even respite care is not available until the disease has progressed to the point the person qualifies for a nursing home.
- Spousal impoverishment protections should be retained along with medically needy programs that assure coverage for persons who do not have enough income to pay their long term care bills on their own.
- Federal nursing home quality standards and effective enforcement should be retained. Key principles—individualized care, personal autonomy and dignity, quality of life, and maximum function—should form the basis of quality assurance in all long term care settings.

Finally, to provide assistance to those families who are trying to plan for their own long term care needs and to delay or avoid dependence on Medicaid, we encourage the Committee to do two things which fall within your broader jurisdiction:

- First, clarify the Internal Revenue Code to include out-of-pocket long term care expenses—including payment for home and community based care and alternative forms of residential care as well as nursing facility care—as deductible medical expenses for personal income tax purposes.
- Second, establish strong uniform national standards for private long term care insurance to protect those consumers who do have the ability to purchase such insurance. To assure accountability for federal tax dollars, it is critical that such standards be part of any legislation to provide tax subsidies for such insurance.

In closing, Mr. Chairman, I cannot help but express the frustration I am sure we all share over the narrow focus of today's hearing. We understand that the budget resolution forces you to operate under these constraints. Unfortunately, some of what Congress may do to restrain the growth of Medicare and Medicaid is likely to exacerbate problems in the health care system as a whole—increasing the numbers of uninsured, shifting costs to the privately insured, and adding new burdens to state and local taxpayers. Real health care cost containment has to come through reform of the entire system. We look forward to the day when we can get back to that larger debate.

Thank you for inviting me to testify. I will be happy to try to answer your questions.

PREPARED STATEMENT OF KATHY MCGINLEY

Mr. Chairman, I am pleased to present the views of the Consortium for Citizens with Disabilities (CCD) Health Task Force on Medicaid reform. The Health Task Force includes over 50 national consumer, professional, health provider, and scientific organizations, working to enact comprehensive health care reform that will meet the needs of children and adults with disabilities and chronic health conditions, and their families.

We thank you for making our views part of the Committee's record. This hearing provides us with the opportunity to stress the vital importance of the Medicaid program for people with disabilities, which includes individuals of all ages with physical and mental impairments, conditions or disorders, and people with acute or chronic illnesses, which impair their ability to function.

Lack of adequate and affordable insurance for acute health care needs is a critical issue for people with disabilities, many of whom have experienced first hand the myriad problems with the current system of private insurance. In particular, they are subjected to the discriminatory practices of the health insurance industry, which either refuses to insure them outright, or will only issue a policy with a pre-existing condition exclusion. For many people with disabilities and/or their families, private health insurance may be unavailable or unaffordable. Between 1989 and 1994, employer health insurance coverage of the under-65 population declined from 66 percent to 59 percent, while Medicaid coverage of this population increased from 9 percent to 14 percent. Clearly, Medicaid is a critical health care safety net for millions of poor Americans.

For those in need of long-term care services and supports Medicaid is the sole payer of last resort. Those who are categorically eligible for Medicaid can receive these services, and depending on the eligibility rules of their State, some middle-class families can receive long-term care services and supports through the Medicaid program after they have "spent down" to poverty. While private long-term care insurance is often proposed as a viable approach to paying for long-term care costs, this insurance is medically underwritten and so it is not available to anyone with a disability or serious chronic illnesses: not to a child with Cerebral Palsy, an adolescent with serious mental illness, an adult with a spinal cord injury, a 50 year old with Alzheimer Disease, or a 70 year old with a stroke. Additionally, all long-term care insurance policies currently available deny benefits to persons with mental impairments other than Alzheimer Disease.

THE IMPORTANCE OF MEDICAID FOR PEOPLE OF ALL AGES WITH DISABILITIES & CHRONIC ILLNESSES

Eligibility: Who is Covered?

The requirements of Federal law, coupled with decisions by individual States in structuring their programs, determine who is actually eligible for Medicaid in a given State. Federal law places limitations on the categories of individuals who can be covered and establishes specific eligibility rules for each category. Within these federal parameters, States are given the option to cover other categories. As a result, there is considerable variability in eligibility from state to state: individuals in similar circumstances may be automatically eligible for coverage in one State, be required to assume a certain portion of their expenses before they can gain coverage in a second State, and be ineligible in a third State.

Medicaid provides health and long term care services for over 36 million people. Among the very diverse Medicaid population, there are approximately 4.9 million children and adults who are blind or have other significant disabilities. According to the Health Care Financing Administration, this population comprises 15 percent of the Medicaid population and account for 31 to 39 percent of Medicaid expenditures. Most of the 4.9 million people with disabilities qualify for Medicaid because they are eligible for the Supplemental Security Income (SSI) program. In some states, individuals with disabilities or their families may be eligible for Medicaid because they have high medical expenses in relation to income. A portion of the women and children who qualify for Medicaid through the Aid to Families with Dependent Children (AFDC) program also have disabilities and serious, chronic illnesses.

In addition, millions of people who are elderly and have physical and mental impairments receive essential services through Medicaid. Together, the Medicaid eligibility categories of "elderly" and "blind and disabled" comprise almost one-third of the Medicaid population and approximately two-thirds of the Medicaid expenditures. These numbers are growing and are expected to continue to grow over the next 25 years as the population ages and as continuing improvements in medical technology are likely to increase the number of children and adults with disabilities.

Consequences of Ending the Entitlement to Medicaid

While some states have taken advantage of the options to expand Medicaid eligibility, many have not. Medicaid reforms that explicitly or implicitly end or weaken the current entitlement to Medicaid will exacerbate state variability in eligibility for federally-subsidized services. This could create significant problems both for individuals with disabilities and for states, if people and families chose to move to one state or another solely to gain access to Medicaid services.

Aggregate spending caps will lead to reductions in the number of people who can receive services because states will not be able to respond to demographic pressures and their attendant costs. While the CCD Health Task Force believes that per capita caps are an improvement over aggregate caps, they still do not take severity of need into account. Additionally, without major reforms in the private health insurance market, increases in the number of Americans without private health insurance are inevitable. Reducing the number of people eligible for Medicaid will simply shift costs to localities and the private sector. People without financial resources will forego care that if provided would prevent expensive complications, hospitals will incur greater costs for uncompensated care, and private insurance rates will rise, If Medicaid is no longer an entitlement, millions of people, including those on SSI, will lose access to critical health and long-term care, services and supports. For persons with disabilities and serious chronic health conditions, the lack of services and supports may well lead to an exacerbation of existing health conditions, the emergence of additional health problems and secondary disabilities, and in some cases to inappropriate institutionalization. For individuals with long-term care needs, lack of Medicaid coverage will place unreasonable pressures on family members, many of whom will have their own economic security undermined paying for health and long-term care costs, and in some cases foregoing employment to care for relatives.

Recommendations

1. For all of these reasons, the CCD Health Task Force strongly opposes any Medicaid reforms that will result in a loss of eligibility for current categories of Medicaid beneficiaries (including the medically needy population). As you deliberate Medicaid reforms, it is essential to put a human face on the numbers you are seeking to cut: a child with mental retardation or cerebral palsy, an adolescent with a traumatic brain injury or a spinal cord injury, a young adult with serious mental illness or Multiple Sclerosis, a middle aged person with Alzheimer's Disease or cancer, an elderly person with a stroke or Parkinson's Disease. The acute and long-term care needs of these persons and millions of other Americans are not going to disappear just because federal funding of Medicaid has been reduced.

2. We strongly recommend a continuation of the federally mandated entitlement to Medicaid for persons eligible for Supplemental Security Income (SSI).

Services: What is Covered?

Medicaid is an important source of federal and state funding not only for acute health care services, but also for long-term services and supports for low income persons of all ages with disabilities and serious chronic illnesses. The effective use of Medicaid funds has enabled the development of state service systems that are meeting the needs of millions of people with disabilities, helping them to become more independent.

The Medicaid program offers federal reimbursement for a wide range of services. States are mandated to offer particular services, which include: inpatient hospital services, outpatient hospital services, rural health clinic services, other laboratory and x-ray services, nurse practitioners' services, nursing facility services, family planning services and supplies; physicians' services, medical and surgical dental services; and early and periodic screening, diagnosis and treatment (EPSDT) for individuals under age 21.

The EPSDT mandate enables the early identification and treatment of serious health and other disabling conditions. For example, it enables a child with hearing loss to receive early intervention services and provides coverage for hearing aids so that the child can develop language skills; for children with conditions such as cerebral palsy, which can impair speech, it covers the cost of augmentative communication devices, enabling these children to communicate with family members and peers.

States also have the option to choose from an array of additional services that meet specialized health care needs. The comprehensive range of specialized services for people with disabilities that states have voluntarily chosen to add to their Medicaid program include:

- Outpatient rehabilitation services
- Occupational, physical, and respiratory therapy
- Speech-language-hearing services
- Clinic services, which can include mental health services, assistive technology, and other services
- Targeted case management for individuals with developmental disabilities or mental health care needs
- Personal care services
- Prosthetics, orthotics, and other medical equipment
- Dental services
- Prescription drugs
- Other health professional services, often targeted to individuals with mental illness or other disabilities

The primary source of long-term services for poor elderly individuals and younger individuals with significant disabilities is the Medicaid Long-Term Care (LTC) program. Services provided include institutional care, group homes, home and community-based waiver services, and community supported living arrangement services. Approximately 85 percent of Medicaid LTC expenditures are for institutional care, including nursing home care. Only 15 percent of expenditures are for home and community-based services. Some of the long-term care services and supports currently covered by Medicaid include:

- Services in institutional and community living situations for individuals with mental retardation/developmental disabilities (e.g., Intermediate Care Facilities);
- Home and community-based long term care, services, and supports (e.g., respite care);
- Inpatient mental health services for children under age 21;
- Day treatment and habilitation;
- Personal assistance, including 24 hour emergency assistance, appropriate to carry out activities of daily living in or outside the home;
- Homemaker/chore services incidental to the provision of such personal assistance services;
- In the case of an individual with a cognitive impairment, assistance with life skills;
- Communication services, including, but not limited to, assistance with interpreting, reading, writing and the use of communication devices, augmentative communications devices and/or telecommunication devices;
- Work-related support services, including but not limited to, ongoing services to assist an individual in performing work-related functions necessary to obtain and perform a job, and personal services while on the job;
- Mobility services in and out of home, including but not limited to: escort and driving, and/or mobility assistance on public transportation;

- The purchase or lease of assistive technology devices for use by individuals with disabilities; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing such devices;

- Coordinating and using other therapies, interventions or services with assistive technology devices (e.g., those associated with existing education or rehabilitation plans or programs); training or technical assistance for an individual with disabilities or where appropriate, the family and personal assistants; and

- Modifications to the principal place of abode of the individual.

As a result of this coverage, many programs that were initially state or locally-financed were able to expand to serve more people with disabilities. State mental health services and school-based health services are also funded in some states with Medicaid dollars. Federal leadership and funding has also enabled states to move forward to develop home and community-based services under waiver programs, to cover children with disabilities (e.g, through the use of the so-called "Katie Beckett" waiver on eligibility), and to provide personal care services as an alternative to nursing home care. These positive steps should not be compromised by diminished federal requirements regarding the use of Medicaid funds. Rather, when federal Medicaid funds are used, they should be used for these critical services, which for many people with disabilities, can mean the difference between life and death, between institutional living and freedom, between inactivity and productivity.

Proposals to block grant or cap the Medicaid program, with no federal requirements to provide health, rehabilitation and home and community-based long term care services and supports, will inevitably lead to a reduction in critical services for millions of people with disabilities.

Recommendations

1. The full array of mandatory and optional services currently provided through the Medicaid program must continue to be reimbursed.

2. Critical services, such as those provided through the EPSDT program, must continue to be mandated.

3. The home and community-based services currently available only through waivers under Section 1915 and other sections should be made simple state options. This would relieve the states of much paperwork burden, increase flexibility but also maintain oversight protections to assure that Medicaid funds are used appropriately.

4. Home and community-based services and supports, such as community supported living arrangements and psychosocial rehabilitation for individuals with mental illness, should be expanded. Current Medicaid disincentives for home and community-based care should be replaced with incentives for the provision of these services.

5. States must continue to be required to finance comprehensive acute and long-term care services and supports. They should be given flexibility and direction to promote the use of home and community-based long-term care services and supports. The current bias for institutional services must be ended.

FEDERAL REQUIREMENTS UNDER REFORM PROPOSALS

State Maintenance of Effort

If funds are given to the states with no requirements whatsoever, these funds may be used for purposes other than providing currently available Medicaid services. If states are allowed to determine how to spend the funds, the health and long-term care service needs of people with disabilities may well be neglected.

Recommendations

1. The use of Medicaid funds must be restricted to the provision of services currently provided through the program.

2. States must be required to maintain at least their current level of funding of Medicaid services.

Federal Oversight and Consumer Protections

An important feature of the Medicaid program, particularly for people with disabilities and specialized health care needs, is that Medicaid law and regulations include strong protections that for 30 years have provided beneficiaries with legal and other tools that enable them to receive the health care to which they are entitled.

The rules are specific and cannot be changed except through a public legislative or administrative process. Beneficiaries have legal recourse if their care is denied or if their rights are abridged. Generally, States must develop statewide plans and must meet minimum standards on eligibility, scope of services and procedural protections. The purpose of these protections is to enhance and assure access to necessary health care.

In the ICF/MR program, for instance, to participate in Medicaid and receive reimbursement, States are required to assure that these programs provide appropriate treatment, a safe environment, and qualified staff. The ICF/MR program has served and continues to serve as a major incentive for states to improve conditions in their institutions in order to qualify for Federal Medicaid payments. The ICF/MR option was quickly selected as a service category by many States. By 1977, 43 states were covering the service, and by 1990 all States were covering ICF/MR services.

Medicaid involvement, through federal oversight, provided states with the incentive to maintain minimum standards for residential programs. The availability of ICF/MR funding provided States with an alternative to placing persons with developmental disabilities in Medicaid-funded nursing homes. ICF/MR funding is used to support large institutions as well as small residences with as few as four people. Federal oversight of state monitoring has resulted in improved conditions and increased protections for some of our most vulnerable citizens. Their rights must not be abridged by the elimination of federal standards.

Important current protections include:

- Individuals must be given an opportunity to apply for Medicaid without delay and to be assisted by a representative, if needed, during the application process.

- States are required to inform applicants and beneficiaries of the benefits available and of their rights and obligations.

- Applicants have a right to notice and an administrative fair hearing before an impartial hearing officer when claims for assistance are denied or not acted upon promptly.

- If States intend to take action that is adverse to an individual, they must give timely notice of the intended change to the applicant or beneficiary. Final decisions must be made within 90 days of the request for a hearing.

- States are restricted in requiring beneficiary copayments. Copayments must be nominal in amount.

Additional protections that promote the quality of care delivered to Medicaid beneficiaries include:

- The amount, duration and scope of services cannot be reduced on the basis of one's condition, diagnosis or type of illness. Thus, beneficiaries are protected from discrimination on the basis of their health or disability.

- Coverage must be available statewide.

- Generally states must give beneficiaries freedom of choice among participating providers (states can waive this requirement for certain alternative delivery systems).

- Under Medicaid's Early and Periodic Screening, Diagnosis and Treatment program, the largest child health program in the country, states are required to make preventive screening available and to arrange for "such other necessary health care, diagnostic services, treatment and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services . . . ." This provision ensures that States will provide all medically necessary services to children with disabilities, even if the services are not currently covered in the State's program.

- States must set payment rates to providers that are adequate to assure beneficiaries reasonable access to services of adequate quality. State payment rates must be sufficient to attract enough providers so that care and services are available to Medicaid beneficiaries at least to the extent they are available to the general population in the geographic area.

- Beneficiaries receiving long-term care in nursing and other facilities have clear rights to obtain quality care. Among other things, nursing homes must assess patient needs, follow a comprehensive care plan, protect patients' funds and provide sufficient care and services so that patients "can attain or maintain the highest practicable physical, mental and psychosocial well-being." Residents must be given notice and opportunity for a hearing before they can be transferred.

Recommendations

1. Comprehensive protections and due process regulations for Medicaid recipients must be retained and information on these protections must be made available to all recipients and providers.

2. Federal oversight and standards must be maintained, particularly for institutional care in facilities such as nursing homes and intermediate care facilities for individuals with mental retardation and developmental disabilities.

MEDICAID MANAGED CARE AND PEOPLE WITH DISABILITIES

For most of Medicaid's history, recipients, like people with private insurance, received their care through a fee-for-service system. In recent years, escalating costs have led most states to establish some form of managed care system for Medicaid beneficiaries. In 1994, 23 percent of Medicaid beneficiaries were enrolled in managed care. The majority of these enrollees are low income women and their children who are recipients of Aid to Families with Dependent Children (AFDC). Although 18 states have offered managed care plans for people with disabilities since 1993, most have exempted people with disabilities and specialized health care needs, and so less than one percent of this population is currently enrolled in them. Several waiver programs, however, are targeted for Medicaid beneficiaries with specific conditions, such as mental illness, AIDS, substance abuse disorders, and diabetes.

Concerns about the Ability of Managed Care to Adequately Serve Persons With Complex and Specialized Health Care Needs

Many states have chosen not to include individuals with disabilities in their mandated managed care programs because of uncertainties regarding adequate service delivery. Doubts are increasingly expressed about the ability of managed care plans to realize savings when serving individuals with disabilities. Many states have little experience with managed care for high-risk populations. Because of limited enrollment, most of the studies of Medicaid enrollees in managed care do not include people with disabilities. Therefore, it is difficult to determine whether moving high-risk Medicaid populations into managed care will save money for the states.

Regardless of the lack of experience with high-risk populations, given current trends in Medicaid expenditures, it is likely that many states will continue to expand enrollment in managed care for Medicaid beneficiaries, including people with complex and specialized health care needs. Kentucky is currently seeking federal approval to expand its KenPAC section 1915(b) program to include people with disabilities and Tennessee is covering persons with disabilities as part of its section 1115 Medicaid project, TennCare. Beneficiaries must enroll in capitated managed care organizations for all but long-term care services. TennCare is preparing to expand coverage to additional groups needing mental health services. Dually-eligible Medicare/Medicaid recipients are typically excluded from mandatory enrollment.

The Consortium for Citizens with Disabilities Health Task Force recognizes that well run managed care plans have the potential to improve access to care for the Medicaid population by promoting preventive and early intervention services; the integration and coordination of care; and by reducing the fragmentation often found in the fee-for-service system. However, we have major concerns about the incentives in managed care to underserve populations with extensive or specialized health care needs.

Problems with Managed Care

Changing from a Medicaid-fee-for-service system to Medicaid managed care has led to many of the same problems facing enrollees in managed care plans in the private sector. Research has shown that managed care leads to a decline in the use of specialist services. While inappropriate and unnecessary utilization should be reduced, there are concerns that appropriate and necessary utilization will also be reduced with negative consequences for persons with complex and specialized health care needs. In many cases, the failure to provide appropriate specialized treatment can lead to longer and more expensive periods of acute illness with attendant high hospital costs, and to the development of secondary disabilities, which additionally limit a person's ability to be independent..

Individuals with severe disabilities and serious chronic illnesses are more likely to depend on specialist care, even for services that are generally considered as primary care. A study in Wisconsin's Medicaid managed care program found that only half of the Medicaid beneficiaries who had a family member with specialized health care needs thought that the HMO could meet those needs due to barriers to referring to specialists.

There are many problems associated with current Medicaid managed care waiver programs. These include: ; (1) a lack of comprehensive evaluations; (2) a lack of involvement by beneficiaries and their advocates in the development of waiver applications or in the implementation and evaluation of waivers; (3) a lack of planning and provisions to assure that services are available for people with complex and specialized health and long-term care needs; (4) a failure to address issues related to transitioning people with complex and specialized health care needs into managed care plans; (5) a lack of grievance procedures and disenrollment provisions for persons who are dissatisfied with the services available; and (6) an absence of clear provisions to assure that adequate and appropriate services will continue to be provided at the end of the waiver period;

In addition, many Medicaid recipients in managed care programs have also lost important protections they had in the fee-for service system. Federal Medicaid law has always included important minimum quality of care and consumer protection standards. Many states that have obtained permission from the U.S. Department of Health and Human Services to implement Medicaid managed care programs have been allowed to proceed without important quality-of-care standards and consumer protections. Thus, most Medicaid managed care programs do not have the important protections that Medicaid beneficiaries have had for over 30 years. The absence of required standards and protections may have negative consequences for individuals with chronic, complex, and special health care needs.

Cost Savings are not Assured

In both Senate and House discussions about ending the entitlement to Medicaid and reducing federal payments for this program, managed care has been proposed as a major means to lower costs to make up for the reduction in federal payments. Yet, as the recent Kaiser Foundation report noted, managed care is unlikely to result in large cost savings, particularly if elderly people and people with disabilities are enrolled. Because these populations frequently have complex and costly health and long-term services needs, determining adequate capitation rates and finding managed care plans that are both willing and able to adequately serve these populations will likely prove difficult.

To address all of these concerns, the CCD Health Task Force makes the following recommendations.

Recommendations

1. People with disabilities and serious chronic illnesses who have complex and specialized health and long-term service needs should be exempted from mandatory enrollment in Medicaid managed care plans.

2. Medicaid managed care plans that serve this population should include provisions for assuring continuity of care, including specialty care.

3. Covered services should include all those needed to treat acute and chronic conditions, to prevent secondary complications and deteriorations in functioning, and to maintain health.

4. Medicaid managed care plans should include provisions that allow specialists to act as gatekeepers when appropriate for persons with serious, complex and specialized health care needs.

5. As research and demonstration projects, Medicaid waiver programs must include a comprehensive evaluation component. Evaluations should include indicators of health, functional outcomes and consumer satisfaction that are appropriate for the population served.

6. All Medicaid managed care plans should have an option for enrollees to access out-of-network services for an additional copayment.

7. States should consider input from the disability and rehabilitation community when developing their Medicaid managed care networks.

8. Physicians in Medicaid managed care plans must be adequately compensated and not placed at inordinate financial risk.

9. Medicaid managed care programs must not include disincentives, financial or otherwise, to the provision of services in home and community-based settings when appropriate.

10. States must assure that private managed care plans meet requirements to assure their financial solvency. There should be federal and state regulations to ensure that financial solvency.

11. Medicaid managed care plans should include effective and timely grievance procedures and disenrollment provisions.

12. Managed care plans must provide participants with clear information on policies, procedures, and grievance mechanisms, and must assure consumer participation in the development of these procedures and mechanisms. Reviews must be conducted in a timely manner and an independent ombudsman program should be required.

13. For persons with disabilities, particularly persons with mental disabilities, strong marketing safeguards are necessary to protect them from inappropriate and misleading marketing practices by managed care entities, such as offers of "prizes" and "rewards" for enrolling.

14. Managed care plans must have timely procedures for obtaining independent second opinions when covered benefits are denied for any reason, including a judgement that they are not "medically necessary." These second opinions must be considered in any grievance review.

CONCLUSION

The Medicaid program is the largest source of federal and state funding for services and supports for individuals with disabilities. Federal Medicaid funds comprise 40 percent of all federal aid to the states. These funds have been used by states to supplement state dollars so that services and supports can be expanded. To meet the needs of people with disabilities, states have elected options which cover such services as community living, assistive technology, mental health services, therapies, respite care, and home nursing. With federal oversight and protections that safeguard the health, safety, and rights of children and adults with disabilities, states have been able to leverage federal and state funds in ways that benefit millions of people.

This investment in children and adults with disabilities is critical if we are to ensure that they receive the health, rehabilitative, and other acute and long term care, services, and supports they need to achieve and maintain independence and to reach their full potential.

The CCD Health Task Force believes that current Congressional proposals to block grant the Medicaid programs, thus changing the existing relationship between the federal and state governments, have the potential to place people with disabilities in jeopardy. Proposals to block grant Medicaid would eliminate the critical "entitlement" status of the program; are likely to lead to an inequitable distribution of federal funds to the states; and will have a substantive negative impact on state budgets and their ability to pay for critical services for children and adults with disabilities.

In conclusion, the CCD Health Task Force asserts that it is imperative that any proposals to change the fiscal relationships between federal and state government, including changes in federal funding formulas or expenditures, must not have a negative impact on the health and well being of people with disabilities. For many individuals with disabilities or specialized health needs, access to Medicaid acute and long term services is critical to their health and their ability to live more independent and productive lives in the community. The Task Force also asserts that federal and state protections and standards must be included in managed care programs in order to protect the health, safety, and rights of people with disabilities and specialized health needs.

We want to thank the Committee again for this opportunity to present our views and our concerns related to the Medicaid program. We look forward to working with you to ensure that any reforms to the program have a positive, not a negative impact on the lives of individuals with disabilities.

If the Committee or its staff require additional information, please contact one of the two CCD Health Task Force Co-Chairs listed below:

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Prepared Statement of Clyde W. Oden, Jr., O.D., M.P.H.

I. INTRODUCTION

Mr. Chairman and members of the Committee, I am Dr. Clyde W. Oden, Jr., the President and Chief Executive Officer of the Watts Health Foundation, Inc., and its federally qualified health maintenance organization (HMO), known as United Health Plan. United Health Plan serves nearly 90,000 members including approximately 60,000 Medicaid beneficiaries in Los Angeles, Orange and San Bernardino Counties. United Health Plan has served Medicaid beneficiaries in Southern California since 1973.

I am pleased to testify today about the Medicaid program on behalf of the Group Health Association of American (GHAA). GHAA is the leading national association for health maintenance organizations (HMOs): its 385 member HMOs serve 80 percent of the 50 million Americans receiving health care from HMOs today.

HMOs have been serving the Medicaid population for many years—enhancing access to quality care and providing a cost-effective and coordinated delivery mechanism for beneficiaries and states. As a result, we come before the committee not to present academic theory or hypothetical cases, but to report on the practical, market-based expertise of United Health Plan and the other GHAA member plans in making HMO options available to Medicaid beneficiaries and the rest of the population. Today, I would like to review four issues with the committee:

- the development and current status of Medicaid managed care;
- our experience at United Health Plan in making Medicaid benefits available over the last 22 years;
- a review of key problems that have arisen; and
- GHAA's views and recommendations for the future of Medicaid.

II. DEVELOPMENT AND CURRENT STATUS OF MEDICAID MANAGED CARE

Medicaid programs—like other large purchasers of health care—have been confronted with the need to meet the health care needs of consumers while constraining the rate of increase in spending for health care services. The challenges for Medicaid have been exacerbated because of some of the unique features of Medicaid and the population that it serves.

- *Fiscal constraints:* As a publicly funded program, Medicaid faces difficult fiscal constraints. Medicaid consumes a large and growing share of federal and state government spending at a time when governing bodies are under enormous pressures to reduce taxes and spending by reducing public budgets.
- *Access problems in the traditional Medicaid program:* The unfortunate reality is that providers of services in the traditional health care delivery system—especially primary care providers—are often less available to the Medicaid population and the communities in which they live. This forces beneficiaries to delay care or seek primary care episodically at hospital outpatient departments and emergency rooms.
- *Diversity and special needs of the Medicaid population:* Medicaid is a large and diverse program, serving individuals who, by definition, have special needs. Poverty is, of course, the unifying characteristic, but Medicaid beneficiaries reflect a spectrum of other needs: pregnant women and children, those with developmental disabilities, aged and disabled individuals in need of chronic care, and those in need of long-term care.

States have turned increasingly to HMOs and other managed care arrangements to address these problems. HMOs have provided an approach that assures cost-effective care; makes providers available to serve Medicaid beneficiaries; emphasizes primary and preventive care, and achieves high levels of patient satisfaction.

It is important to recognize that managed care options under state Medicaid programs have taken a variety of forms. Health plans that accept capitation payments for the full range of covered services—primarily HMOs—represent the largest and fastest growing model in the Medicaid program. However, states have also included in their programs other types of health plans. For example, some states permit participation by plans that are capitated for only selected services. Other states have entered into fee-for-service contracts with physicians who receive a small flat monthly fee for serving a gatekeeper function (known as primary care case management (PCCM). Of these forms of managed care, only HMOs assume full financial risk and deliver comprehensive benefits for each enrollee.

HMO enrollment has grown rapidly in recent years. As of June, 1994, a total of 4.8 million Medicaid enrollees were in fully capitated health plans—the vast majority of which are HMOs. As Table 1 shows, HMOs and other fully capitated plans account for the largest proportional growth—a 91 percent increase over the enrollment just one year earlier. Total managed care enrollment, including HMOs, reached 7.6 million beneficiaries—about one-fourth of Medicaid enrollees—and these trends are continuing this year.

Table 1—Medicaid Managed Care, June 1994
(Total enrollment and percent increase over June 30, 1993)

Type of Managed Care	Enrollment	% Increase over 93
Unduplicated total, all managed care	7.6 million	57%
Fully capitated plans	4.8 million	91%
Primary Care Case Management (PCCM)	2.4 million	59%
Partially capitated health plans	.8 million	9%

Source: NIHCM/Lewin-VHI, February, 1995.

The results have been promising. The Lewin-VHI report noted in the table above reviewed studies of Medicaid's experience with organized delivery models and found the following:

- emergency room and inpatient use is lower in managed care arrangements;
- managed care increases satisfaction, largely because it allows beneficiaries to gain access to private physicians;
- access is slightly better than in traditional programs;
- quality is similar to that in traditional fee-for-service Medicaid; and
- while cost experience is early and in some cases conflicting, some studies report costs to states are lower by five to fifteen percent.

III. EXPERIENCE AT UNITED HEALTH PLAN

United Health Plan's health care delivery system is a network consisting of more than 2,000 physicians representing more than 100 medical groups spanning delivery models ranging from integrated health networks, to community health centers, and independent physician practice associations. Our network includes more than 60 hospitals and 60 nursing homes, 10 home health agencies and other community institutions. We enroll between 1,500 to 2,000 new Medicaid members per month.

Over our more than two decades of experience in serving Medicaid beneficiaries on a prepaid basis we have seen even more dramatically promising results than indicated in the Lewin report. Those Medicaid beneficiaries that have enrolled with our health plan and who have never been part of an organized health care delivery system, typically come to us with very poor health.

They are not used to having a single primary care physician, and are not respectful of appointment times. Their only reference for primary care has been the emergency room of the public hospitals. We have to teach our new members how to properly use the services provided by their primary care physicians. The results of such health education lead to dramatic decreases in emergency room utilization. However, it takes about a year for such enrollee behavior to be demonstrated.

Patient satisfaction with our organized system increases over time, after our Medicaid members accept the fact that quality health care requires personal responsibility and discipline. The greatest challenge is getting a Medicaid member to understand that they can't go outside of the network on any given day, at any given time, for any given reason, and that emergency rooms are for true medical emergencies. Once this fundamental understanding has been achieved, beneficiary concerns about the system are greatly reduced. Over time, the level of member satisfaction is about the same regardless of the source of coverage: Medicaid, Medicare and/or commercial coverage.

With regard to quality, we have found substantial differences in the level of care received by our Medicaid members in our HMO compared to their previous fee-for service status. We found significant unmet needs on the part of our new Medicaid members. The evidence of under service is tied principally to the lack of continuity of care with a primary health care provider. We have found lower immunization rates, and much lower screening rates for preventive health care under fee-for-service.

Our greatest health delivery problem in serving the Medicaid population is the transitory nature of their eligibility. In California, neither guaranteed eligibility or continuous enrollment has ever been implemented . As a result, there is an involuntary turnover of nearly 60 percent per year. This major problem has prevented all California HMOs from being able to do what they are best capable of doing: providing continuous, comprehensive, high quality care.

Finally, our California experience has shown something else. In the mid 1970's there were more than 50 prepaid health plans serving Medicaid beneficiaries. However, only about a dozen at that time met federal standards for HMOs. Most of the other state licensed plans had no history of serving any population on a prepaid basis and were created solely for the Medicaid market. California at the time had no significant regulatory scheme to monitor the actions of all of those plans, and no consistent standard for licensing those plans. As a result there were serious scandals that set back the managed care movement in our state. Once stiff, but appropriate regulations were adopted with a new law known as the Knox-Keene Health Services Plan Act, the number of prepaid health plans that contracted to serve Medicaid dropped from 54 to 12.

Our experience in serving Medicaid beneficiaries in California has led us to conclude that there is no substitute for having appropriate regulations that realistically address the issues of financial solvency, quality measures, provider networks, commitment to the local community, and perhaps, most importantly, having experienced regulators that understand the nature and challenges of prepaid organized delivery systems. After California, no other state needed to repeat the problems of the 1970s, but of course, as recent history has demonstrated, there have been some repetitions of the California experience.

United Health Plan's 22 year history with the Medicaid population has been in our judgment beneficial for both the members and the plan; and has continually proven to be a viable source of providing not only health care services, but also providing members with the skills to become actively involved with improving their health.

IV. KEY ISSUES AND PROBLEMS

GHAA knows from experience that properly designed and implemented Medicaid managed care programs can improve coordination of care and program efficiency. GHAA member plans have worked collaboratively with the Health Care Financing Administration and state Medicaid agency directors to promote sound programs through development of guidelines in the areas of quality oversight, marketing and solvency standards. However, in the past, problems have arisen in developing and implementing state Medicaid managed care programs.

As I have stated, other states have failed to learn from California's lesson. Recent news accounts report marketing problems in Maryland where state employees were accused of selling names of Medicaid enrollees to a few health plans so that the plans could target their marketing efforts. Florida has also seen serious marketing and enrollment problems in its recent effort to quickly implement a Medicaid managed care program. This arose, in large part, from the state's initial decision to expand Medicaid managed care capacity by using health plans that met standards less stringent than those for commercial HMOs. The state allowed "state defined HMOs" to serve only Medicaid beneficiaries—with lower capital requirements than HMOs, and less ongoing regulation. In addition, while commercially licensed HMOs in Florida are required to obtain private sector accreditation, there was no such requirement for the Medicaid plans.

Mr. Chairman, our long years of experience with this program indicate that there are two related sources of these problems:

- they arise when states do not develop, and vigorously enforce, appropriate standards for health plans seeking to serve the Medicaid population; and
- they arise when states seek to expand Medicaid managed care capacity too rapidly.

Further, while Medicaid managed care can enhance coordination of care and quality as it constrains the rate of increase in spending, it can work only if financing is adequate to pay for benefits. Otherwise, we face a system of government underfunding of plans serving Medicaid—which attracts the wrong kinds of plans, or what is more important, fails to attract quality HMOs, and results in declining service and quality for beneficiaries who require care. Moreover, GHAA believes that in establishing payments to plan, states should adopt reasonable and predictable methods that reflect the costs of meeting the health care needs of the individuals who enroll.

V. GHAA POLICY CONSIDERATIONS FOR MEDICAID REFORM

The Group Health Association of America recommends that the following policies be considered as the federal government and states develop changes in the Medicaid program.

1. Commitment to beneficiaries: Medicaid should maintain its commitment to provide access to health care services for low-income individuals and their families.

2. Effective state implementation, and enforcement of standards: States need to plan adequately for the initiation and ongoing monitoring of Medicaid managed care. Key elements of successful state Medicaid managed care programs include:

- adequate enrollment/disenrollment administrative and data systems;
- assistance to beneficiaries in the process of health plan selection and enrollment/disenrollment; and
- well-focused regulatory standards, and adequate and knowledgeable staff to implement and enforce those standards. The staff must be able to:

—evaluate the ability of organizations to meet entry standards for Medicaid managed care; and

—conduct sophisticated monitoring of compliance with the standards on an ongoing basis.

Further, Medicaid managed care program development should involve input (and buy-in) from stakeholders including the provider community; existing HMOs and other managed care plans participating in the Medicaid program; and consumer/Medicaid beneficiaries. An inclusive development process can take advantage of the knowledge and expertise of those who have been deeply involved with the existing programs and lay the foundation of successful working relationships as new programs are implemented.

3. Health plan standards: All HMOs and other Medicaid managed care plans should meet comparable standards to ensure the integrity of participating plans, including standards for quality, access, and solvency.

Standards for entities participating in the Medicaid program should be no less stringent than standards for organizations serving the private sector. These standards include the following:

- *Quality.* Plans that obtain private sector accreditation should be deemed to have met Medicaid program standards where a determination is made that the private sector standards are at least as stringent. Performance measures should be developed that apply to all Medicaid providers and plans, regardless of type of plan or payment method. These measures should be carefully selected to provide a set of key quality indicators of special significance to Medicaid programs and the populations they serve. They should take into consideration the limited nature of periods of continuous enrollment as a result of changes in eligibility status. For this reason, Medicaid managed care measures must be different from those for the private sector where members are commonly continuously enrolled for much longer periods. Special attention should be given to the type of quality management and quality improvement systems found in the plan. As effective outcomes measures are developed in the private sector, these measures should apply to plans serving Medicaid with adjustments which recognize the special circumstances that are found in the Medicaid population.
- *Access.* All programs and organizations that provide Medicaid covered services through provider networks should ensure the availability and accessibility of services to beneficiaries who enroll. Critical elements include the location of providers, their hours of operation and arrangements for after-hours care. In addition, services should be provided in a culturally competent manner that is cognizant of and responsive to the social and economic factors affecting health care access. These factors include cultural diversity, language diversity, housing, transportation, child care and other environmental factors.
- *Solvency.* All organizations participating in Medicaid managed care programs should meet solvency standards that ensure they will have the financial capability to provide promised services. As new organizations take on the responsibility for both the delivery and financing of care for Medicaid beneficiaries, it is critical that they demonstrate their plans for financial stability and their ability to meet solvency standards comparable to those applicable to organizations licensed to serve the private sector.

4. Benefits: To permit the expansion of HMO and other managed care plans in Medicaid, benefits should remain comprehensive, and include outpatient and preventive services, as well as inpatient and emergency services. In addition, programs should be in place to coordinate Medicaid services offered by health plans with other resources, such as state-provided social and transportation services, in order to maximize the benefit to Medicaid beneficiaries.

5. Choice/Marketing and Enrollment: Medicaid managed care programs should offer beneficiaries a periodic opportunity to make a choice among participating plans to permit beneficiaries to elect the option that best meets their needs. The time frame for initial enrollment should be adequate to ensure that beneficiaries can be notified of the types of options available to them and can obtain information on benefits, providers and how to access services. States should work closely with participating organizations to educate beneficiaries about the choices available to them and to develop marketing and enrollment mechanisms that promote informed choice and guard against abuses. Enrollment materials should clearly set out requirements for accessing covered health services. Mechanisms for default enrollment of beneficiaries who do not elect a plan should ensure that they are well-informed about the plans to which they are assigned and that they have an opportunity to appeal assignment to a plan that they determine does not meet their needs.

6. Payments: Medicaid payments to HMOs and other managed care plans should be reasonable and should reflect the utilization and costs of the population; the payment rates should be actuarially sound. It is important to develop alternatives to payment models that tie payment rates to Medicaid fee-for-service payments, because as the fee-for-service sector diminishes it becomes an inappropriate reference point for the establishment of payment rates for health plans.

VI. CONCLUSION

As previously stated, the Medicaid system has evolved and is currently undergoing a maturing process. I have given a brief insight into the successes and challenges of United Health Plan as one of 385 members of GHAA. In closing, on behalf of GHAA, I presented key issues that have arisen in Medicaid managed care programs and GHAA's recommendations for future program design.

Mr. Chairman, the Group Health Association of America looks forward to working with the Congress, the Administration, and the states in implementing careful changes in the Medicaid program, and I would be pleased to answer any questions that the Committee may have at this time.

Prepared Statement of June E. O'Neill

Mr. Chairman and Members of the Committee, it is my pleasure to be here today to discuss the status of the Medicaid program. The rapid increases in Medicaid spending and the growing prominence of the program in the federal budget present a serious challenge to the Congress.

Between 1988 and 1993, overall Medicaid spending increased at an average annual rate of 16 percent, while the federal share increased at the remarkable rate of 20 percent per year. Yet over the same period national health expenditures rose by less than 10 percent a year. Without changes in policy, Medicaid expenditures are expected to continue to rise faster than other health expenditures. With federal spending of $89 billion in 1995, Medicaid now accounts for about 6 percent of the federal budget. By 2002, that share is projected to increase to 8 percent, or about $178 billion.

The conference agreement on the budget resolution for 1996 assumes a reduction in the rate of growth of Medicaid spending to 4.8 percent a year averaged over the seven-year period from 1995 to 2002. Thus, by 2002 Medicaid spending would grow to only $124 billion, well below CBO's current projection of federal Medicaid spending in that year. Clearly, reducing the growth in program spending will require both the Congress and the states to make significant policy changes.

My statement today addresses four topics:

- An overview of the Medicaid program,
- Past trends in program spending,
- CBO's projection of future spending under current law, and
- Considerations in modifying the Medicaid program to meet the requirements of the budget resolution.

OVERVIEW

Medicaid is the nation's major program providing medical and long-term care services to low-income populations. The federal and state governments jointly fund the program. The states administer it, however, and though they are subject to federal guidelines, they retain considerable discretion over all aspects of program operation. The federal share of total Medicaid spending in a state varies inversely with the per capita income of the state, subject to a lower limit of 50 percent and an upper limit of 83 percent.

Medicaid Beneficiaries

The Medicaid program has always covered most recipients and potential recipients of cash welfare benefits provided through the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income programs. In addition, eligibility has been extended to large numbers of poor and near-poor children and pregnant women, as well as to certain low-income Medicare beneficiaries. In 1993, more than 33 million people received Medicaid benefits. Children under the age of 21 are by far the largest group of Medicaid beneficiaries, accounting for almost half of the total in 1993. About 12 percent of beneficiaries were elderly and 15 percent disabled. Most of the remainder were nondisabled adults.

The majority of Medicaid beneficiaries are poor or near-poor. In 1992, according to the Census Bureau's Current Population Survey, 61 percent of the noninstitutionalized Medicaid population was in families with income below the poverty level and 74 percent was in families with income below 133 percent of the poverty level.

Provision of Services

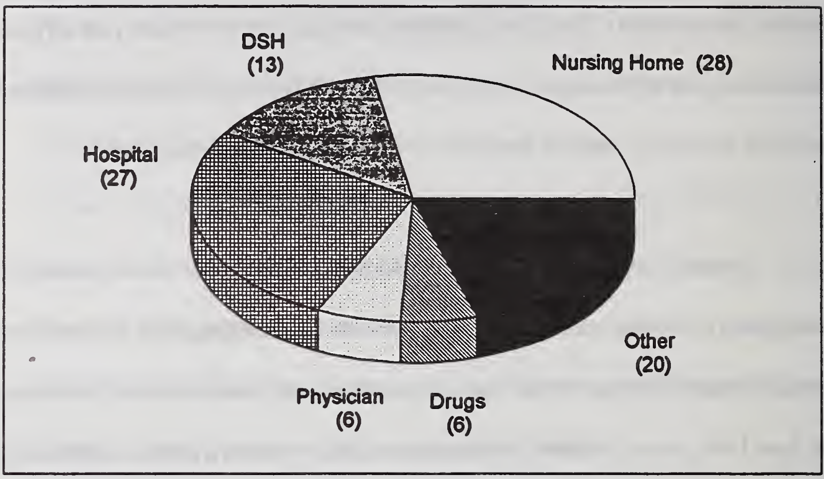
Medicaid covers both acute medical services and long-term care. The federal government requires all states to provide a core group of services, including hospital, physician, and general nursing facility services. States have the option, however, to cover an extensive range of services in addition to the mandated ones, and all of the states do so. Optional services include drugs, dental services, eyeglasses, and personal care services. The typical Medicaid beneficiary receives acute care services free of charge or for a nominal copayment. However, beneficiaries often face limited access to providers, many of whom are unwilling to see Medicaid patients.

Concern about access to providers was an important factor in the decision of some states to develop managed care arrangements for providing acute care services to some of their Medicaid beneficiaries--generally nondisabled adults and children. By June 1994, about 8 million Medicaid beneficiaries--almost a quarter of the total--were enrolled in managed care plans in 42 states and the District of Columbia.

Expenditures by Type of Service

The largest share of Medicaid expenditures is for hospital and nursing home services, which accounted for more than half of the total in 1993 (see Figure 1). Hospital expenditures include payments to hospitals for inpatient and outpatient services received by Medicaid beneficiaries. In addition, disproportionate share hospital (DSH) payments are made to hospitals that serve disproportionately large numbers

FIGURE 1. DISTRIBUTION OF MEDICAID EXPENDITURES BY CATEGORY OF SERVICE, FISCAL YEAR 1993 (In percent)



SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-64.

NOTES: Nursing home expenditures include spending for nursing home facilities and intermediate care facilities for the mentally retarded.

Hospital expenditures include spending for inpatient and outpatient care.

DSH = disproportionate share hospital payments.

of Medicaid and uninsured patients. Nursing homes include general nursing facilities as well as intermediate care facilities for the mentally retarded.

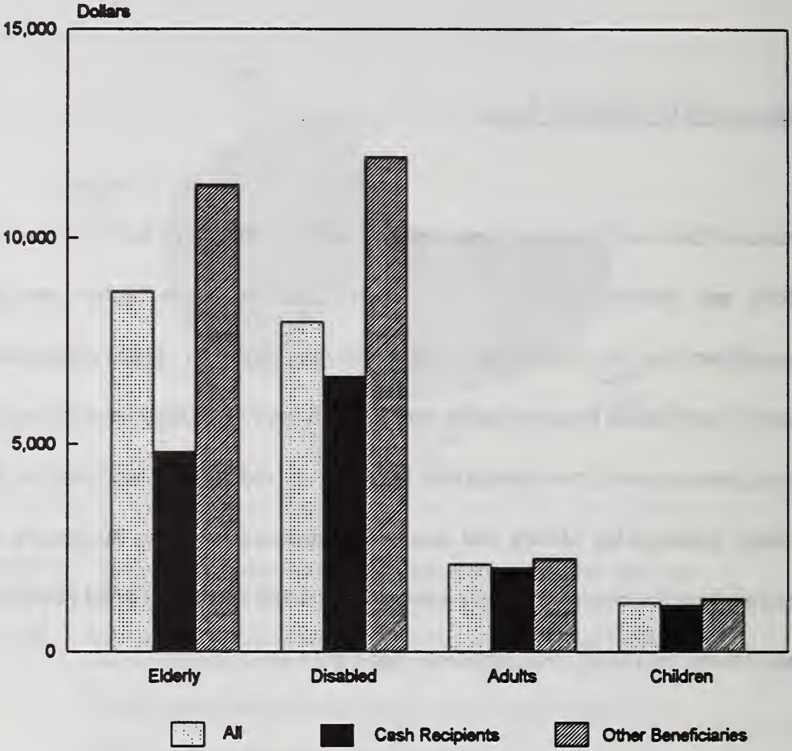
Expenditures by Eligibility Status

Because of their use of nursing home services and their extensive acute care needs, elderly and disabled Medicaid beneficiaries generate much higher medical expenditures than do children and other adults (see Figure 2). Some elderly and disabled beneficiaries become eligible for Medicaid because of their need for costly nursing home services, even though they have not received cash welfare benefits. As a result, although the elderly and disabled represented less than 30 percent of Medicaid beneficiaries in 1993, they accounted for about two-thirds of all Medicaid expenditures, excluding DSH payments (see Figure 3).

Variation in State Expenditures

Both the levels of and recent trends in Medicaid expenditures vary considerably from state to state (see the appendix). A number of reasons account for that variation: the size and makeup of the beneficiary population, the coverage of optional services, the use of services by beneficiaries, payment levels for providers, differences in

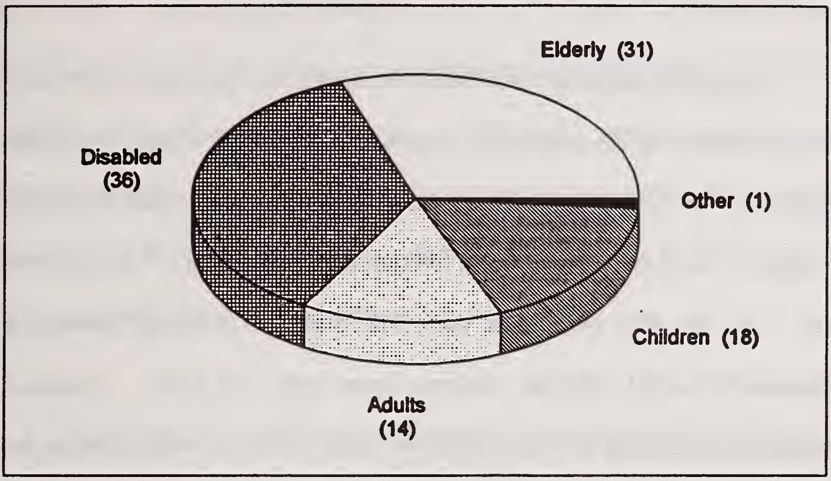
FIGURE 2. MEDICAID EXPENDITURES PER BENEFICIARY, FISCAL YEAR 1993



SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-2082 and HCFA Form-64.

NOTE: Excludes administrative costs and disproportionate share payments.

FIGURE 3. DISTRIBUTION OF MEDICAID EXPENDITURES BY ELIGIBILITY GROUP, FISCAL YEAR 1993 (In percent)



SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-2082 and HCFA Form-64.

NOTE: Excludes administrative costs and disproportionate share payments.

underlying health care costs, and variations in federal matching rates. In addition, some states have raised DSH payments substantially by taking advantage of certain financing schemes, whereas others have not.

Because of those factors, total Medicaid expenditures vary much more widely among the states than one might expect, given the relative size of their low-income populations. In California, for example, about 5.8 million people were in families with income below the poverty level in 1993 compared with about 3 million in New York. But in 1993, New York spent $18 billion on Medicaid (excluding administrative costs), whereas California spent only $14 billion. Medicaid expenditures (excluding DSH payments) per enrollee also vary widely among the states, ranging from less than $2,000 in Alabama, California, and Mississippi in 1993 to more than $5,000 in New York.[1]

TRENDS IN SPENDING

Since 1975, Medicaid expenditures have grown at an uneven rate, and recent patterns of growth have differed from those of Medicare, private health insurance, or national health expenditures (see Table 1).[2] For analytic purposes, the trend in Medicaid expenditures for the 1975-1993 period can be divided into three distinct periods: 1975 to 1981, when Medicaid spending grew rapidly but still remained at virtually the same rate as national health expenditures; 1981 to 1988, when Medicaid spending grew relatively slowly and somewhat less rapidly than national health expenditures; and 1988 to 1993, when Medicaid spending grew extremely rapidly and much faster than national health expenditures. During that last period, federal Medicaid spending increased by close to 20 percent per year, while Medicaid spending by state and local government increased at an annual rate of less than 12 percent.

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[1] Colin Winterbottom, David W. Liska, and Karen M. Obermaier, *State-Level Databook on Health Care Access and Financing* (Washington, D.C.: Urban Institute, 1995).

Between 1975 and 1981, Medicaid spending grew at about 14 percent a year, the same as national health expenditures. Private health insurance and Medicare expenditures both grew at about 18 percent a year during that same period. Since the number of beneficiaries remained virtually unchanged at around 22 million, the growth in Medicaid spending was attributable to increases in prices and utilization per beneficiary.

Medicaid expenditures grew relatively slowly during the 1981-1988 period, at an annual rate of about 9 percent. Medicare and private health insurance spending

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[2] CBO's analysis of spending trends is based on data from the national health accounts. In developing those estimates, the Health Care Financing Administration reduced the amount of disproportionate share payments to hospitals when such payments were offset by taxes and donations paid by the same facilities. The effect is to reduce the estimates of state Medicaid spending in the 1990s below the levels actually reported by the states. See Katherine R. Levit and others, "National Health Spending Trends, 1960-1993," *Health Affairs*, vol. 13 (Winter 1994), pp. 14-31.

TABLE I. NATIONAL HEALTH EXPENDITURES BY SOURCE OF PAYMENT, 1975-1993 (By calendar year)

Source of Payment	1975	1980	1985	1990	1993
Billions of Dollars					
National Health Expenditures	132.6	251.1	434.5	696.6	884.2
Private Health Insurance	32.0	72.1	139.8	236.9	296.1
Medicare	16.4	37.5	72.2	112.1	154.2
Medicaid	13.5	26.1	41.3	75.4	117.9
Federal	7.4	14.5	22.8	42.7	76.1
State and local	6.1	11.6	18.4	32.7	41.8
Other	70.7	115.3	181.2	272.1	316.0
Average Annual Growth Rate from Previous Year Shown (Percent)					
National Health Expenditures	n.a.	13.6	11.6	9.9	8.3
Private Health Insurance	n.a.	17.6	14.2	11.1	7.7
Medicare	n.a.	18.0	14.0	9.2	11.2
Medicaid	n.a.	14.1	9.6	12.8	16.0
Federal	n.a.	14.3	9.5	13.3	21.2
State and local	n.a.	13.9	9.7	12.2	8.5
Other	n.a.	10.3	9.5	8.5	5.1
Average Annual Growth Rate over Indicated Periods (Percent)					
			1975-1981	1981-1988	1988-1993
National Health Expenditures			14.0	9.8	9.5
Private Health Insurance			17.7	11.7	9.9
Medicare			18.3	10.3	11.5
Medicaid			14.5	8.9	16.4
Federal			15.0	8.8	19.6
State and local			13.8	9.0	11.7
Other			10.8	8.6	6.3

SOURCE: Congressional Budget Office based on data from the Health Care Financing Administration, Office of National Health Statistics.

NOTE: n.a. = not applicable.

grew at 10 percent and 12 percent, respectively, and national health expenditures grew at about 10 percent. As in the previous period, the growth in Medicaid expenditures primarily reflected price increases and increases in utilization per beneficiary; the number of beneficiaries grew only slightly during the period, reaching about 23 million in 1988. Indeed, in spite of the effects of the 1981-1982 recession, the number of Medicaid beneficiaries actually fell slightly between 1981 and 1983. Several factors contributed to that decline, particularly cutbacks in the AFDC program combined with new Medicaid options that granted states greater flexibility in determining which groups of children to cover. Although the Congress authorized expanding eligibility for children and pregnant women beginning in 1984, the early expansions were tied to categorical eligibility for welfare and did not have a major impact on the number of beneficiaries.

The 1988-1993 trends represented a break with past patterns. Previously, the growth in Medicaid spending had trailed behind that of private health insurance and Medicare. During the 1988-1993 period, however, Medicaid expenditures soared, rising at an average annual rate of about 16 percent, although national health expenditures grew at less than 10 percent. Private health insurance expenditures grew at about 10 percent during the period, and Medicare spending grew at less than 12 percent. The most striking increases occurred between 1990 and 1992, when Medicaid spending jumped by over 40 percent. Several factors contributed to

Medicaid's dramatic growth: sharp rises in Medicaid enrollment, increased payments to providers, and financing schemes and disproportionate share payments.

Rapid Increases in Medicaid Enrollment

In contrast to earlier periods, 1988 to 1993 was marked by swift growth in the number of Medicaid beneficiaries. Not only did the number of children covered by the program increase sharply, but enrollment of population groups that are more costly to serve also grew rapidly.

Increases in the AFDC Caseload. After remaining relatively stable through most of the 1980s the AFDC caseload soared from 3.7 million families in 1988 to about 5 million in 1993 and 1994--a 35 percent increase. (Over the same period, the number of AFDC recipients increased from 10.9 million to 14.2 million). Several factors contributed to the caseload rise including the recession and the weak job market of 1990 to 1993.[3]

Consistent with the pattern of change in AFDC participation, the number of Medicaid beneficiaries who received cash welfare payments remained virtually constant (at about 16.5 million) throughout most of the 1980s, but rose after 1988 to 19.6 million in 1993. To some extent, the growth in the enrollment of Medicaid beneficiaries who were eligible for cash welfare benefits itself may have spurred growth in welfare caseloads. Some states began conducting aggressive outreach efforts to enroll children and pregnant women in Medicaid in the early 1990s and, in so doing, identified families who were eligible for cash welfare benefits but were not receiving them. The number of AFDC families has recently begun to turn down somewhat.

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[3] See Congressional Budget Office, "Forecasting AFDC Caseloads, With An Emphasis on Economic Factors," CBO Staff Memorandum (July 1993).

Expansions in Eligibility. Beginning in 1984 and continuing through 1990, the Congress authorized a series of mandatory and optional expansions in Medicaid eligibility that allowed for a considerable increase in coverage among those who do not receive cash benefits. Low-income children and pregnant women were the primary focus of those expansions, but the target populations also included the elderly and the disabled.

Of particular importance were the options granted to the states in the Omnibus Budget Reconciliation Act of 1986, which severed the required link between Medicaid and welfare eligibility. A rapid succession of mandates and options for covering low-income children and pregnant women followed, as well as requirements for covering low-income Medicare beneficiaries. The most recent mandatory expansion of the program, authorized in the Omnibus Budget

Reconciliation Act of 1990, requires states to provide coverage to all poor children under 19 who were born after September 30, 1983. That requirement means that mandatory expansions in Medicaid eligibility will continue under current law through 2002.

Such expansions in eligibility, along with efforts to streamline the eligibility process, have brought about large increases in the number of Medicaid beneficiaries who do not receive cash welfare benefits. The number of those beneficiaries rose at an average annual rate of about 17 percent between 1988 and 1993, having risen at an average rate of about 3 percent between 1981 and 1988. By 1993, over 40 percent of Medicaid beneficiaries did not receive cash welfare benefits, compared with less than 30 percent in 1988. Much of that increase, however, was among children, who are the least expensive beneficiaries to cover. The proportion of total expenditures attributable to beneficiaries who do not receive cash benefits increased only slightly over the period.

Although Medicaid expansions increased the number of Medicaid beneficiaries substantially over the late 1980s and 1990s, private insurance might otherwise have covered many of those new beneficiaries. As shown in Table 2, the proportion of all children under age 18 receiving Medicaid increased from 15.5 percent in 1988 to almost 24 percent in 1993--a gain of 8.3 percentage points. At the same time the gain in Medicaid coverage was almost fully offset by a decline in the

TABLE 2. HEALTH INSURANCE COVERAGE OF CHILDREN UNDER 18, 1988 AND 1993 (In percent)

	1988	1993
All Children		
Any coverage	87.0	86.4
Private health insurance	73.5	67.6
Group health insurance	63.9	57.3
Medicaid	15.5	23.8
Not covered	13.0	13.6
Children Above Poverty		
Any coverage	90.0	88.3
Private health insurance	85.9	81.3
Group health insurance	75.9	70.5
Medicaid	5.5	11.1
Not covered	10.0	11.7
Children Below Poverty		
Any coverage	74.6	79.9
Private health insurance	22.5	21.1
Group health insurance	14.5	12.4
Medicaid	56.8	67.0
Not covered	25.4	20.1

SOURCE: U.S. Bureau of the Census.

NOTE: The percentages of children with private health insurance and with Medicaid do not add to the total percentage covered. Some children had other sources of coverage, and some had coverage from more than one source.

proportion of children covered by a parent's group health plan (from 63.9 percent to 57.3 percent).

Consequently, the status of coverage for children overall remained about the same--nearly 87 percent were covered from some source in both 1988 and 1993. Among poor children, however, there was a net increase in coverage as the proportion covered by Medicaid increased by 10 percentage points while the low proportion covered through a parent's employment policy declined slightly. Among nonpoor children, the increase in Medicaid coverage--from 5.5 percent to 11.1 percent--was fully offset by a decline in coverage under a parent's group policy. As a result, the proportion of nonpoor children with insurance did not increase (it actually decreased slightly--from 90 percent to 88.3 percent). Nevertheless, the fact that the rise in Medicaid coverage among children was significantly offset by a decline in coverage under a parent's group policy does not prove cause and effect. Children might have been enrolled in Medicaid because their parents lost jobs or coverage and therefore took advantage of the more generous conditions of Medicaid eligibility.

However, a recent academic study suggested that workers were less likely to participate in employer-sponsored insurance if they had dependent family members who were eligible for Medicaid.[4] The study also found some evidence that when those workers did participate in employer-sponsored insurance, many opted for individual rather than family coverage. The analysis focused on the 1987-1992 period, during which Medicaid eligibility for children and pregnant women expanded dramatically. An estimated 50 percent to 75 percent of the increase in Medicaid coverage was linked to a reduction in private insurance coverage. Although a wide range of estimated effects exists, the extent to which public insurance crowds out private insurance coverage is important in assessing future Medicaid policy changes.

Increases in High-Cost Beneficiaries. Medicaid expenditures depend not only on the total number of beneficiaries but also on their distribution among the different categories of eligibility. For a given number of beneficiaries, the higher the proportion of elderly and disabled beneficiaries, the greater spending will be. The proportion of pregnant women among the nondisabled adult population also has an important impact on spending.

The number of disabled Medicaid beneficiaries expanded rapidly in the early 1990s, rising from 3.5 million in 1988 to 5 million in 1993--an increase of 44 percent. Over that period, Medicaid expenditures for the disabled grew from about $19 billion to about $40 billion--an increase of over 100 percent. Factors contributing to the growth in the disabled population included expansions in the Supplemental Security Income program for children and increasing numbers of beneficiaries with mental illness. The number of disabled beneficiaries is expected to expand more rapidly than total beneficiaries for the remainder of the decade.

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[4] David M. Cutler and Jonathan Gruber, *Does Public Insurance Crowd Out Private Insurance?* Working Paper No. 5082 (Cambridge, Mass: National Bureau of Economic Research, 1995).

The expansions in eligibility for pregnant women during the 1988-1993 period also brought into the Medicaid program a beneficiary group that, by definition, has extensive acute medical care needs. The number of nondisabled adult beneficiaries who did not receive cash welfare payments more than doubled over the period--from 1.4 million to 2.9 million--and payments for that group rose from $1.5 billion to $6.5 billion.

Increases in Payments to Providers

During the 1980s, providers in several states filed lawsuits challenging the reasonableness and adequacy of Medicaid's reimbursement rates for hospitals and nursing homes. Those lawsuits were filed under the Boren Amendment (originally enacted as part of the Omnibus Reconciliation Act of 1980 and expanded in the Omnibus Budget Reconciliation Acts of 1981 and 1987), which required states to pay rates that were "reasonable and adequate" to meet those costs that would be incurred by "efficiently and economically operated" facilities. A decision by the U.S.

Supreme Court in 1990 established that providers have an enforceable right to such rates and that they may sue state officials for declaratory and injunctive relief.

Following the Supreme Court's ruling, decisions favoring providers were handed down in several states. The mere threat of a suit under the Boren Amendment may have been sufficient to make some states increase payments. Even though recent court decisions have favored the states in suits brought under the Boren Amendment, the National Governors' Association is trying to have the amendment repealed. Some states are concerned that the Boren Amendment limits their ability to use managed care effectively to control Medicaid expenditures. Although repealing the Boren Amendment might reduce Medicaid spending, it is difficult to determine what the magnitude of the effect would be.

Financing Schemes and Disproportionate Share Payments

In the late 1980s and early 1990s, many states developed financing schemes to generate part of their share of Medicaid expenditures. Those schemes, which involved voluntary donations from providers, taxes on providers, and intergovernmental transfers, drew down federal matching dollars for what were often illusory Medicaid expenditures.[5] Such financing mechanisms were closely linked to the rapid growth in DSH payments that occurred during the period (sometimes as a response to actual or potential litigation under the Boren Amendment). According to researchers at the Urban Institute, DSH payments rose from less than $1 billion in 1990 to more than $17 billion in 1992.[6] But taxes or donations from providers almost certainly offset some of the state share of those amounts. Consequently, the actual spending on health services attributable to DSH was less than nominal DSH payments.

CBO'S SPENDING PROJECTIONS

The Congressional Budget Office (CBO) projects that without policy changes the federal share of Medicaid payments would rise from $89 billion in 1995 to $232 billion in 2005, which represents an average annual growth rate of 10 percent (see Table 3). The Medicaid projections developed by the Office of Management and Budget (OMB) are lower than CBO's. OMB assumed that lower-than-anticipated spending in 1994 represented a change in the program that would be sustained

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[5] General Accounting Office, *Medicaid: States Use Illusory Methods to Shift Program Costs to the Federal Government* (August 1994).

[6] John Holahan, David Liska, and Karen Obermaier, *Medicaid Expenditures and Beneficiary Trends, 1988-1993* (Washington, D.C.: Urban Institute, September 1994).

TABLE 3. PROJECTIONS OF THE FEDERAL SHARE OF MEDICAID EXPENDITURES AND THE NUMBER OF BENEFICIARIES, 1995-2005 (By fiscal year)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Average Annual Growth Rate, 1995-2005 (Percent)
Billions of Dollars												
Expenditures												
Benefits	77	87	96	108	119	132	146	160	176	193	211	10.6
DSH payments	9	9	9	10	10	11	11	11	11	11	12	3.2
Administration	3	4	4	5	5	6	6	7	7	8	9	10.1
Total	89	99	110	122	135	148	163	178	195	212	232	10.0
Millions of People												
Beneficiaries												
Aged	4.3	4.6	4.8	5.1	5.3	5.5	5.8	6.0	6.2	6.4	6.7	4.4
Blind and disabled	6.0	6.4	6.8	7.1	7.5	7.9	8.1	8.3	8.5	8.7	8.9	4.1
Adults	7.8	8.0	8.2	8.3	8.5	8.7	8.9	9.1	9.2	9.4	9.6	2.0
Children	17.9	18.7	19.5	19.9	20.4	20.8	21.3	21.8	22.3	22.7	23.2	2.6
Total	36.8	38.4	40.0	41.2	42.4	43.7	44.9	45.9	47.0	48.1	49.1	2.9
Billions of Dollars												
Comparison of Medicaid Projections												
CBO	89	99	110	122	135	148	163	178	195	212	232	10.0
OMB	88	96	105	115	125	136	149	163	178	194	212	9.2

SOURCES: Congressional Budget Office and the Office of Management and Budget.

NOTES: Numbers may not add to totals because of rounding. The total beneficiary line includes Medicaid beneficiaries whose classification is unknown.

DSH = disproportionate share hospital.

throughout the projection period. By contrast, CBO projects that growth will return to more historical levels.

Four factors drive CBO's projections of Medicaid expenditures for the next several years: disproportionate share payments, growth in beneficiaries, cost increases, and residual growth. The contribution of those factors to increased growth cannot be estimated with precision, in part because each factor interacts with all of the others. Moreover, the usual uncertainty associated with projections of federal spending is compounded in the case of Medicaid, in which decisions affecting federal spending are made at both federal and state levels and current policy allows for considerable latitude in making many of these decisions.

Disproportionate Share Payments

The Congress took action in 1991 to limit the use of provider taxes and donations and also to place a cap on the growth of DSH payments. The Omnibus Budget Reconciliation Act of 1993 enacted further restrictions on DSH payments. It is still too early to assess the full impact of those provisions, but DSH payments fell in 1993 and 1994 and rapid growth in the future is unlikely. CBO projects that DSH payments will increase by 5 percent a year through 1999 and then grow at 2 percent annually for the remainder of the projection period. Thus, DSH payments are assumed to be a decreasing share of overall Medicaid expenditures over time. CBO projects that DSH payments will account for a small percentage of overall Medicaid growth during the 1995-2005 period.

Growth in Beneficiaries

The total number of Medicaid beneficiaries is expected to increase from 36.8 million in 1995 to 49.1 million in 2005. Little of this expansion is attributable to population increase. In fact, according to census data, the population age 65 and over is expected to increase at an annual rate of only 0.6 percent between 1995 and 2002, while over the same period the number of children under age 19 is projected to decline slightly. Nonetheless, under current policy, CBO projects increases in beneficiaries because of continuing expansion in eligibility and participation.

Some expansion in eligibility will occur because current law requires states to phase in coverage of poor children. However, since children are the least costly group of beneficiaries and only one age cohort is being added each year, those additions should not prompt rapid growth in expenditures. The numbers of children and pregnant women covered by the program are also likely to increase as a result of expansions initiated by states and authorized under section 1902(r)(2) of the Social

Security Act. But the number and magnitude of such expansions are highly uncertain.

The growth in the number of disabled Medicaid beneficiaries is expected to exceed that of the overall number of beneficiaries--4.1 percent a year versus 2.9 percent. Such rapid growth reflects the continuing effects of the Social Security Administration's outreach to the disabled population, a broader interpretation of disability than in earlier years, and a growing number of individuals reaching ages at which a higher incidence of disability occurs. In part because of that increase in high-cost beneficiaries, about 45 percent of projected growth in overall Medicaid spending stems from increases in caseload.

Cost Increases

It is not possible to measure pure price inflation in medical services since increases in the cost of providing those services also reflect changes in quality and new modes of treatment. The data needed to separate price and quality changes have been unavailable in the medical sector.

CBO uses various factors in an effort to try to measure increases in the cost of providing Medicaid services. Each state has discretion in setting payment rates for providers and in updating those rates. Those increases may use some form of the hospital market basket index, other state price inflators, state legislation, and negotiations between agencies and providers. Generally, national measures of inflation at most affect the payment rates of states only indirectly, making projections of price inflation for Medicaid highly uncertain. CBO estimates that over the 1995-2005 period, changes in cost will account for approximately 30 percent of the projected increase in Medicaid outlays.

Residual Growth

Finally, CBO's projections assume that all other factors combined will increase Medicaid spending by about 3 percent a year over the projection period. That residual growth factor encompasses state innovations, changes in utilization, the use of more complex technologies, changes in the benefit packages that states offer, increases in payment rates above general inflation, changes in the use of alternative financing mechanisms to generate federal dollars, and the impacts of section 1115 waivers and managed care.

Although some of those factors may be budget neutral or serve to reduce Medicaid outlays, the net effect of all of them combined accounts for about 25 percent of overall growth in Medicaid expenditures over the projection period. Three of the factors are of particular importance for federal policy: alternative financing mechanisms, section 1115 waivers, and the use of managed care.

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 limited the ability of states to generate federal matching dollars without corresponding state expenditures. But other mechanisms for achieving that goal--such as intergovernmental transfers--still exist. Quite possibly, the use of intergovernmental transfers will expand in the future or states will develop new mechanisms to draw down federal matching payments.

Several states have obtained--or are seeking--statewide demonstration waivers under section 1115 of the Social Security Act. The purposes of those waivers are generally to enroll more Medicaid beneficiaries in managed care and to expand insurance coverage to poor and near-poor population groups. Although 12 states now have waivers approved and an additional 9 states have waiver applications under review, the number of states that will actually obtain and implement waivers (and over what time period) is extremely uncertain. Some of the states that have had waivers approved, for example, are now backing away from or postponing implementation.

The implications of the waivers for projections of Medicaid outlays are further complicated by the terms and conditions of the Health Care Financing

Administration (HCFA) governing budget neutrality. Any expansions of coverage under the waivers are supposed to be budget neutral. Because of the ways in which budget neutrality is defined, however, as well as the uncertainty surrounding projections of the states' Medicaid expenditures in the absence of waivers, determining whether a waiver would indeed be budget neutral is difficult.

Many states, with the encouragement of the federal government, are also moving quickly to enroll Medicaid beneficiaries in managed care plans, both to improve access to care and to control costs. Managed care has been shown to be effective in a variety of acute care settings, but the evidence to date on the effectiveness of managed care in containing Medicaid costs is limited.[7] Moreover, most states have concentrated thus far on developing managed care options for children and nondisabled adults, and those groups account for only about one-third of Medicaid spending. It will be more difficult to develop appropriate and cost-saving models of managed care for elderly and disabled beneficiaries (particularly those in long-term care), who account for the bulk of Medicaid expenditures.[8] Although such models are being developed, states may find it difficult to achieve large savings from managed care in the near future in the Medicaid program as a whole.

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[7] Robert E. Hurley, Deborah A. Freund, and John E. Paul, *Managed Care in Medicaid: Lessons for Policy and Program Design* (Ann Arbor, Mich.: Health Administration Press, 1993).

[8] Deborah A. Freund and Robert E. Hurley, "Medicaid Managed Care: Contribution to Issues of Health Reform," *Annual Reviews of Public Health*, vol. 16 (1995), pp. 473-495.

MEETING THE REQUIREMENTS OF THE BUDGET RESOLUTION

The conference agreement on the concurrent budget resolution for fiscal year 1996 assumes that the federal share of Medicaid spending would increase from $89 billion in 1995 to $124 billion in 2002. The average annual rate of growth assumed over those years would be 4.8 percent, which is well below the 10.4 percent growth rate that CBO has projected would occur in the absence of any policy change. Recent growth rates for federal Medicaid outlays have been even higher, reaching an estimated 16.8 percent on average between 1990 and 1995. However, some of that Medicaid explosion is attributable to the DSH bubble, which appears to have been deflated.

Reducing the average annual growth rate of Medicaid expenditures over the next seven years to 4.8 percent will not be easy. Although the populations under age 18 and over age 65 are expected to grow slowly--below 1 percent--the number of Medicaid beneficiaries is projected to grow more rapidly, considering the increases in participation likely to occur under current policy. Meeting the target growth rate could limit the extension of Medicaid eligibility to additional groups as well as limit the expansion of services and increases in reimbursements to providers. Improvements in the efficiency with which Medicaid is operated, however, could help stretch resources.

The Congress could consider a number of programmatic and financial policies to achieve the budget resolution's federal spending levels for Medicaid. Programmatic policies could alter eligibility rules for enrollment or reduce the services covered by the program. Financial policies could alter the way in which the federal government pays for Medicaid but allow the states more latitude in deciding whether to change eligibility rules, coverage, or the way in which services are delivered. Examples of such policies include making reductions in the federal matching formula and imposing caps on federal matching payments to states. An even greater departure from the current system would convert Medicaid into a block grant to the states. That is the option assumed in the House budget resolution.

As a budgeting tool, block grants offer a more certain way for the federal government to control the level of expenditures. Under the current system, the federal government matches what the states spend and the states have considerable control over eligibility, services offered, and reimbursement rates for providers. Yet the states have frequently argued that the rules laid down by the federal government greatly restrict their ability to innovate and to develop the program and delivery systems that would most efficiently meet the needs of their residents.

Although a block grant approach would be likely to enhance the ability of the federal government to control costs and could give the states greater flexibility and incentives to improve efficiency, it nonetheless raises a number of other concerns.

With tightening fiscal constraints, would the states allow adverse impacts on access to care or the quality of care? Could the federal government retain a role in ensuring access and quality and still allow the states the flexibility they desire? Those issues of accountability are likely to become more prominent under a block grant.

If the Congress decided to convert the Medicaid program into some form of block grant, the issue of how to allocate federal funds among the states would probably become paramount. It is clearly possible to develop allocation formulas based on such seemingly objective criteria as a state's fiscal capacity and the distribution of poor people with particular health care needs. But using those criteria, which the current federal matching formula reflects in only the most limited way, could result in a major redistribution of federal Medicaid dollars among the states. Both the initial distribution of block grant funds among the states and how those amounts should grow over time would raise very difficult and important policy questions.

CONCLUSION

Many of the nation's governors are now seeking less federal control of the Medicaid program to enable the states to meet the health care needs of their low-income populations more effectively. The desire of the states for greater flexibility plus the intent of the Congress to reduce significantly the rate of growth of federal Medicaid spending make the program ripe for change. How to limit program growth in an appropriate way is the challenge facing the Congress and the states.

APPENDIX

STATE MEDICAID AND POVERTY DATA

TABLE A-1. STATE STATISTICS ON MEDICAID EXPENDITURES AND POVERTY, 1993

State	Total Medicaid Expenditures (In millions of dollars)	Federal Medicaid Expenditures (In millions of dollars)	Percentage of All Federal Medicaid Expenditures	Federal Matching Percentage	Poverty Population (In thousands)	Percentage of U.S. Poverty Population
Alaska	301.1	160.6	0.2	50.0	52	0.1
Alabama	1,635.9	1,170.9	1.6	71.5	725	1.8
Arkansas	1,017.8	758.0	1.0	74.4	484	1.2
Arizona	1,375.4	918.3	1.3	65.9	615	1.6
California	14,060.9	7,043.4	9.8	50.0	5,803	14.8
Colorado	1,281.1	700.5	1.0	54.4	354	0.9
Connecticut	1,992.9	999.8	1.4	50.0	277	0.7
District of Columbia	654.6	327.7	0.5	50.0	158	0.4
Delaware	251.0	126.2	0.2	50.0	73	0.2
Florida	4,861.8	2,680.7	3.7	55.0	2,507	6.4
Georgia	2,766.1	1,723.8	2.4	62.1	919	2.3
Hawaii	385.7	193.6	0.3	50.0	91	0.2
Iowa	959.0	603.8	0.8	62.7	290	0.7
Idaho	291.0	207.7	0.3	71.2	150	0.4
Illinois	4,908.1	2,461.9	3.4	50.0	1,600	4.1
Indiana	2,785.7	1,763.4	2.4	63.2	704	1.8
Kansas	1,073.4	624.5	0.9	58.2	327	0.8
Kentucky	1,823.7	1,309.3	1.8	71.7	763	1.9
Louisiana	3,906.3	2,888.3	4.0	73.7	1,119	2.8
Massachusetts	3,976.1	1,996.8	2.8	50.0	641	1.6
Maryland	1,972.2	989.8	1.4	50.0	479	1.2
Maine	827.9	511.9	0.7	61.8	196	0.5
Michigan	4,403.5	2,465.8	3.4	55.8	1,475	3.8
Minnesota	2,138.8	1,184.5	1.6	54.9	506	1.3
Missouri	2,244.6	1,356.5	1.9	60.6	832	2.1
Mississippi	1,175.2	928.9	1.3	79.0	639	1.6
Montana	328.0	235.6	0.3	70.9	127	0.3
North Carolina	2,839.0	1,875.3	2.6	65.9	966	2.5
North Dakota	258.2	188.6	0.3	72.2	70	0.2
Nebraska	560.0	344.2	0.5	61.3	169	0.4
New Hampshire	412.3	207.3	0.3	50.0	112	0.3
New Jersey	4,883.0	2,447.0	3.4	50.0	866	2.2
New Mexico	582.2	434.0	0.6	73.9	282	0.7
Nevada	389.6	205.2	0.3	52.3	141	0.4
New York	18,015.0	9,033.3	12.5	50.0	2,981	7.6
Ohio	5,161.5	3,114.7	4.3	60.3	1,461	3.7
Oklahoma	1,075.8	753.4	1.0	69.7	662	1.7
Oregon	946.8	592.3	0.8	62.4	363	0.9
Pennsylvania	6,468.0	3,599.2	5.0	55.5	1,598	4.1
Rhode Island	820.4	440.7	0.6	53.6	108	0.3
South Carolina	1,639.4	1,170.8	1.6	71.3	678	1.7
South Dakota	264.0	188.0	0.3	70.3	102	0.3
Tennessee	2,645.3	1,787.7	2.5	67.6	998	2.5
Texas	7,030.3	4,544.2	6.3	64.4	3,177	8.1
Utah	475.5	358.2	0.5	75.3	203	0.5
Virginia	1,788.5	898.0	1.2	50.0	627	1.6
Vermont	259.2	155.9	0.2	59.9	59	0.2
Washington	2,263.1	1,249.8	1.7	55.0	634	1.6
Wisconsin	2,094.0	1,269.7	1.8	60.4	636	1.6
West Virginia	1,199.7	915.6	1.3	76.3	400	1.0
Wyoming	133.1	90.0	0.1	67.1	64	0.2

SOURCES: Health Care Financing Administration, HCFA Form-64; *Federal Register*, vol. 59, no. 221 (November 17, 1994); and the 1994 Current Population Survey of the Bureau of the Census.

NOTES: Expenditures do not include administrative costs. Totals do not include U.S. territories. Expenditure data are for fiscal years. Poverty data are based on calendar years.

TABLE A-2. MEDICAID EXPENDITURES BY STATE, 1988 AND 1993 (By fiscal year)

State	Total Medicaid Expenditures, 1988 (In millions of dollars)	Total Medicaid Expenditures, 1993 (In millions of dollars)	Average Annual Rate of Growth, 1988-1993	Percentage of Total Medicaid Expenditures, 1988	Percentage of Total Medicaid Expenditures, 1993
Alaska	102.8	301.1	24.0	0.2	0.2
Alabama	466.8	1,635.9	28.5	0.9	1.3
Arkansas	428.4	1,017.8	18.9	0.8	0.8
Arizona	183.1	1,375.4	49.7	0.4	1.1
California	5,592.7	14,060.9	20.0	10.9	11.2
Colorado	480.9	1,281.1	26.1	0.9	1.0
Connecticut	834.7	1,992.9	19.0	1.6	1.6
District of Columbia	379.2	654.6	11.5	0.7	0.5
Delaware	100.9	251.0	20.2	0.2	0.2
Florida	1,524.7	4,861.8	26.1	3.0	3.9
Georgia	1,136.0	2,766.1	19.5	2.2	2.2
Hawaii	159.8	385.7	19.3	0.3	0.3
Iowa	477.1	959.0	15.0	0.9	0.8
Idaho	118.5	291.0	19.7	0.2	0.2
Illinois	1,915.0	4,908.1	20.7	3.7	3.9
Indiana	1,024.0	2,785.7	22.2	2.0	2.2
Kansas	328.9	1,073.4	26.7	0.6	0.9
Kentucky	714.2	1,823.7	20.6	1.4	1.5
Louisiana	939.4	3,906.3	33.0	1.8	3.1
Massachusetts	2,078.4	3,976.1	13.9	4.0	3.2
Maryland	931.2	1,972.2	16.2	1.8	1.6
Maine	325.4	827.9	20.5	0.6	0.7
Michigan	2,047.5	4,403.5	16.6	4.0	3.5
Minnesota	1,183.2	2,138.8	12.6	2.3	1.7
Missouri	714.7	2,244.6	25.7	1.4	1.8
Mississippi	443.9	1,175.2	21.5	0.9	0.9
Montana	152.1	328.0	16.6	0.3	0.3
North Carolina	965.7	2,839.0	24.1	1.9	2.3
North Dakota	159.6	258.2	10.1	0.3	0.2
Nebraska	240.8	560.0	18.4	0.5	0.4
New Hampshire	172.0	412.3	19.1	0.3	0.3
New Jersey	1,748.2	4,883.0	22.8	3.4	3.9
New Mexico	229.0	582.2	20.5	0.4	0.5
Nevada	96.5	389.6	32.2	0.2	0.3
New York	9,717.2	18,015.0	13.1	18.9	14.3
Ohio	2,363.5	5,161.5	16.9	4.6	4.1
Oklahoma	593.1	1,075.8	12.6	1.2	0.9
Oregon	364.6	946.8	21.0	0.7	0.8
Pennsylvania	2,544.0	6,468.0	20.5	4.9	5.1
Rhode Island	334.0	820.4	19.7	0.6	0.7
South Carolina	472.3	1,639.4	28.3	0.9	1.3
South Dakota	125.9	264.0	16.0	0.2	0.2
Tennessee	1,009.5	2,645.3	21.2	2.0	2.1
Texas	2,017.2	7,030.3	28.4	3.9	5.6
Utah	196.6	475.5	19.3	0.4	0.4
Virginia	776.3	1,788.5	18.2	1.5	1.4
Vermont	113.4	259.2	18.0	0.2	0.2
Washington	932.1	2,263.1	19.4	1.8	1.8
Wisconsin	1,139.0	2,094.0	13.0	2.2	1.7
West Virginia	315.0	1,199.7	30.7	0.6	1.0
Wyoming	46.7	133.1	23.3	0.1	0.1

SOURCE: Health Care Financing Administration, HCFA Form-64.

NOTES: Expenditures do not include administrative costs. Totals do not include U.S. territories.

PREPARED STATEMENT OF DIANE ROWLAND, SC.D.

Thank you Mr. Chairman and members of the Committee for this opportunity to provide a historical perspective on the Medicaid program and the role it plays in financing health and long-term care services for low-income Americans. I am Diane Rowland, Senior Vice President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on the Future of Medicaid.

The Kaiser Commission on the Future of Medicaid is a fourteen member bi-partisan national commission established by the Henry J. Kaiser Family Foundation in 1991 to serve as a Medicaid policy institute and forum for analyzing, debating, and evaluating future directions for health care for poor and vulnerable populations. I am pleased to be here today to share the work of the Commission and discuss Medicaid's role as a safety net for the health and long-term care needs of 36 million low-income Americans.

THE STRUCTURE AND ROLE OF MEDICAID

Since its enactment in 1965 as companion legislation to Medicare, Medicaid has been on the front lines in meeting the health needs of our nation's most vulnerable populations. Medicaid has evolved from a program providing financing to states for health coverage of their welfare population to a program that now finances health and long-term care services for one in ten Americans. In its thirty years, Medicaid has enabled millions of low-income Americans to gain access to needed health services. It has helped to close the gaps in care between the poor and non-poor, eased financial burdens, and provided a safety net for the most needy Americans. It has been a major force in shaping health and long-term care services for low-income families and aged and disabled Americans.

Medicaid's role as a health insurer and safety net for vulnerable Americans is visible throughout the health care system. Medicaid finances care for one in four American children, pays for one-third of the nation's births, assists 60 percent of people living in poverty, pays for half of all nursing home care, and accounts for 13 percent of all U.S. health care spending. It is the source of insurance for 13 percent of the non-elderly population and supplements Medicare by paying premiums and cost sharing for one in ten elderly and disabled Medicare beneficiaries. Its funding is the major source of federal financial assistance to the states, accounting for 40 percent of all federal-grant-in-aid payments to states.

Authorized under Title XIX of the Social Security Act in 1965, Medicaid is a means-tested entitlement program that is jointly financed by the federal and state governments. States elect to participate in Medicaid and federal requirements and state choices determine Medicaid's structure. States design and operate the program within federal guidelines that determine the population groups and services for which the federal government will match state expenditures. Some eligibility groups and services are required, but others are left to state option. The federal government pays 50 to 79 percent of program expenditures, depending on the state's per capita income.

To be eligible for federal matching payments, the federal statute requires states participating in Medicaid to cover certain low-income groups, most notably recipients of cash assistance under the Aid to Families with Dependent Children (AFDC) program and low-income pregnant women and young children, and to provide basic benefits, including hospital and physician services. In addition to these basic coverage and benefit requirements, states have the option to cover other low-income groups who are not receiving cash assistance and to provide more comprehensive benefits, such as prescription drug coverage or dental care, and still receive federal matching funds. Because the states make very different decisions regarding program design, there is substantial variation across states in who is covered, what benefits are offered, how services are delivered, and how much is spent for care.

In reality, Medicaid is four separate programs, configured and operated somewhat differently in each of the fifty states and the District of Columbia. For 16 million children and 7 million adults in low-income families, Medicaid is a health insurance program with comprehensive benefits and little or no cost-sharing. For nearly 4 million low-income elderly people and 5 million low-income people with disabilities, Medicaid has multiple roles. It is a long-term care program for home-and community-based services and the dominant source of public financing for nursing home care. In addition, Medicaid is a supplementary insurance program to Medicare paying Medicare's premiums and cost-sharing requirements and covering additional services, most notably prescription drugs and long-term care, for low-income Medicare beneficiaries. Finally, Medicaid is a health insurance program for low-income disabled adults who do not have Medicare coverage.

From the perspective of who is served, Medicaid is predominantly a program assisting low-income families, but from the perspective of how Medicaid dollars are spent, Medicaid is predominately a program serving the low-income aged and disabled population. As shown in Figure 1, adults and children in low-income families make up nearly three-fourths of beneficiaries, but account for only 27 percent of spending. In contrast, the elderly and disabled account for 27 percent of beneficiaries and the majority (59 percent) of spending because of their intensive use of acute care services and the costliness of long-term care in institutional settings.

The use of services under Medicaid reflects the differing needs of the low-income population served by Medicaid and state coverage choices. The key services that Medicaid programs must cover are physician and hospital services, laboratory and x-ray services, nursing facility services for persons over age 21, prenatal care, family planning, and screening and treatment for children (EPSDT). The primary optional services that states elect to cover are intermediate care facilities for the mentally retarded, prescription drugs, vision care and eyeglasses, dental care, and clinic services.

As shown in Figure 2, acute care spending under Medicaid accounts for 46 percent of program spending, HMO and Medicare premium payments for 5 percent and long-term care for 35 percent with the remaining 14 percent of spending for payments for disproportionate share hospitals (DSH). DSH payments are a recent component of Medicaid spending directed at hospitals with high volumes of care to the low-income population and do not directly relate to expenditures for specific population groups.

The elderly and disabled use the bulk of long-term care services and account for half of acute care spending. Because they use more services and the services they use are more expensive, the cost to Medicaid to cover aged and disabled beneficiaries is substantially higher than the cost for children and adults in low-income families. As shown in Figure 3, the average per enrollee Medicaid cost in 1993 for a child was $955 and for a non-aged adult was $1,717 compared to $7,216 per disabled beneficiary and $8,704 per elderly beneficiary. With over an eight-fold difference between the cost of a child and elderly beneficiary, the cost of any state's Medicaid program is largely determined by the mix of beneficiaries covered by the program.

THE COST OF MEDICAID

Medicaid is an expensive program because it provides health insurance coverage and long-term care financing for many of the nation's poorest and most disabled individuals. Its benefits are comprehensive with little or no cost-sharing because most Medicaid beneficiaries have incomes that are significantly below the federal poverty line of $14,800 per year for a family of four. They have neither the income nor the resources to pay for care on their own. By providing comprehensive benefits, Medicaid helps to overcome the financial barriers that can impede access to needed services.

Medicaid provides a safety net for individuals with the most catastrophic of illnesses—chronic illnesses for children that leave them disabled for a lifetime, mental illness and retardation that requires intensive care in the community or in an institutional setting, and long-term nursing home care for the aged and disabled. Medicaid's average cost for a pregnant women or child without complex medical needs is often substantially lower than a comparable private health insurance premium whereas the average cost for a severely retarded individual on Medicaid can exceed $50,000 per year, an expense not covered by most private insurance.

Medicaid has become a major budgetary commitment for both the federal and state governments. In recent years, Medicaid expenditures have escalated rapidly, more than doubling from $51 billion in 1988 to $125 billion in 1993. It is projected that total federal and state spending for Medicaid will exceed $158 billion this year and grow to $308 billion by 2002. The federal share, roughly 56 percent of total expenditures, is projected to grow from $90 billion in 1995 to $177 billion in 2002. Federal expenditures for Medicaid now account for 6 percent of the federal budget while state Medicaid funds account for 13 percent of state spending.

Historical rates of growth for Medicaid have been more moderate than increases in private health care spending, but in the late 1980s and early 1990s, the costs for Medicaid soared with annual rates of increase in excess of 25 percent between 1990 and 1992. The excessive growth rates during this period were attributable to several factors, including a national recession and growth in the number of people eligible for Medicaid, inflation in health care spending, and states' use of statutory loopholes to leverage federal dollars.

Spurred by federal requirements to increase coverage of pregnant women and children, state efforts to cover more low-income uninsured, and court-required expansions in coverage of the disabled, enrollment increased from 22 million in 1988 to 32 million in 1993. As shown in Figure 4, low-income children constituted the largest portion of the growth in Medicaid enrollment, but the numbers of disabled individuals covered by the program also increased substantially. However, as shown in Figure 5, coverage of additional children with their low per capita costs played a relatively minor role in Medicaid's rapid growth during the 1990s.

The major factor contributing to this sudden escalation in program spending was that some states generated additional federal dollars from Medicaid by using provider taxes and donations and disproportionate share hospital (DSH) payments as alternative financing strategies to increase the base payments that had to be matched by the federal government. The federal share of DSH payments alone grew from $800 million in 1990 to 10.1 billion in 1992. As shown in Figure 6, state efforts to maximize federal Medicaid funding had the most pronounced effect on increases in Medicaid spending between 1991 and 1992, when over half of the annual increase in Medicaid spending was attributable to rapid growth in Federal DSH payments to states. By 1993, DSH payments accounted for 14 percent of total Medicaid spending.

The use of special financing techniques to generate additional federal financing varied significantly across states. Disproportionate share hospital (DSH) payments were intended to be used to compensate hospitals with a high volume of low-income patients, but were used in some states to increase the share of federal payments to the state. The states that used DSH financing heavily include Alabama, Kansas, Louisiana, Missouri, New Hampshire, New Jersey, South Carolina, and Texas. In each of these states, DSH payments represented more than 20 percent of total Medicaid expenditures.

With legislation enacted in 1991 and implemented in 1993 to restrict state use of tax and donation financing strategies and curb the growth in DSH payments, the annual rate of growth in Medicaid spending has now dropped back to historical levels. The changes in the provider tax provisions and the cap on DSH payments have clearly closed some of the mechanisms used by states to increase federal Medicaid payments. From 1992 to 1993, the program grew by 11 percent and future projections assume an annual growth rate of about 10 percent. Future increases are expected to be mostly driven by inflation and enrollment growth due to increases in the number of people in poverty and expanded coverage of children below poverty.

Given the size and scope of Medicaid, sustaining an annual spending increase of 10 percent requires a substantial commitment of new funds each year. With budgetary pressure and the desire to reduce spending at both the federal and state level, restraining the annual increases in Medicaid spending has taken on new urgency. How expenditures for the program are shared and managed between the federal and state governments is at the heart of the policy debate over Medicaid's future. Forces Shaping Medicaid's Future

Today, the Medicaid program fills many diverse roles as it provides federal funding to states to match their expenditures for coverage of their indigent and elderly and disabled populations. From the states' perspective, it is the source of federal rules and mandates that require states to cover specific populations and benefits and that constrain state flexibility in setting provider payment rates and in adopting broad scale use of managed care. Yet, the matching funds provided by the federal government through Medicaid also enable states to improve the services they provide to their low-income population, to respond to changes in the economy that affect the number of poor and uninsured in each state, to accommodate population growth, and to undertake health and long-term care reform at the state level.

The Medicaid program's current structure as an entitlement for low-income, elderly, and disabled Americans and as an entitlement to states for open-ended federal matching funds for individuals and services that fall within federal guidelines provides a safety net for both states and their low-income residents. It, however, offers limited fiscal control for the federal government because federal spending levels are largely determined by state choices over who is covered and how much is paid for services.

The tensions between the federal government and state governments over the structure and financing of Medicaid have notably increased in recent years. Federal mandates requiring coverage of more low-income children and pregnant women, providing assistance with Medicare cost-sharing and premiums for low-income aged and disabled Medicare beneficiaries, and protecting income for spouses of nursing home residents combined with requirements for reasonable cost payments to hospitals, nursing homes, and community health centers have limited state discretion over program spending and imposed new costs. States, struggling to finance care for an expanded population and to limit the increases necessary to pay for that care from already strapped state budgets, have employed a variety of methods to control costs, as well as, maximize federal funding. The resulting pressures underscore today's debate over financing and flexibility.

The Pressure on Medicaid from the Uninsured Population

Medicaid is the primary source of financing and coverage for the low-income population and has been a critical force in moderating the growth in America's uninsured population. As shown in Figure 7, fifty-eight percent of all Americans living in poverty and 82 percent of all poverty-level pregnant women and young children are now covered by Medicaid. If the growth in Medicaid over the last five years had not offset the decline in employer-based insurance for working families, an additional nine million Americans would be uninsured today, increasing the percent of non-elderly Americans without insurance from 18 to 22 percent.

Today, 41 million Americans, two-thirds of whom have incomes below 200 percent of the federal poverty level, are uninsured. But, Medicaid as it is currently structured is limited in its ability to broaden coverage of the uninsured. Medicaid is a means-tested entitlement program. Only persons who meet stringent and state-specific income and assets limits and who fall into particular "categories," such as people receiving cash assistance or low-income children and pregnant women, are eligible. Despite recent extensions of coverage to poor children and pregnant women, millions of uninsured low-income Americans, most notably poor single individuals and childless couples, remain beyond the program's reach.

As a result, many states have sought waivers from the federal Medicaid eligibility requirements in order to use Medicaid as a building block in their state health care reform efforts. With waivers, federal matching funds can be used to help pay the cost of insuring low-income individuals who are not in Medicaid's traditional coverage categories. As shown in Figure 8, twelve states now have federal waivers of Medicaid law (known as Section 1115 waivers) that allow them to experiment with changes in the scope and structure of their Medicaid programs to cover additional low-income uninsured people and to use managed care to restructure the delivery and financing of services. With the growing budgetary pressures on states, many states are turning to 1115 waivers as a way to gain broader flexibility over their Medicaid programs.

Potential for Savings from Managed Care

Low levels of participation in Medicaid by private physicians, heavy reliance by program beneficiaries on care in clinics and hospital emergency and outpatient departments, and concerns about both the cost and quality of care under the fee-for-service medical care system have led many states to turn to managed care as a model to coordinate care and help control costs for the Medicaid population. Medicaid managed care enrollment has grown steadily in the last decade from 800,000 enrollees in 1983 to 7.8 million in 1994, as shown in Figure 9. Today, 23 percent of Medicaid beneficiaries, predominantly poor children and their parents, are enrolled in managed care. More than half of Medicaid managed care enrollees are in Health Maintenance Organizations (HMOs) or similar organizations that provide a full range of services for a fixed capitation payment per enrollee.

Managed care has the potential to improve the delivery of care by integrating and coordinating services to enrollees and promoting early intervention and primary care to reduce hospitalizations and reliance on emergency rooms as a site of care. Capitated managed care systems also offer the potential to constrain Medicaid costs and make spending more predictable by setting a fixed payment per enrollee and putting the health plan at risk for delivering needed services.

Managed care is not, however, an instant solution to Medicaid's access and cost problems. Managed care works most effectively if the enrolled population is stable and can receive ongoing preventive and primary care, but a program such as Medicaid which determines eligibility on the basis of income has significant eligibility turnover because people lose coverage due to fluctuations in income and employment. As a public program, Medicaid also operates under budget constraints that have often resulted in substandard provider payment rates. In a capitated managed care arrangement where the incentive is to keep utilization low, substandard payment rates could discourage participation by mainstream plans and compromise quality and access. Moreover, significant savings for the overall Medicaid program cannot be achieved if enrollment of Medicaid in managed care focuses only on low-income families. As shown in Figure 10, only 23 percent of overall program spending is related to acute care services for low-income children and adults. Even if managed care is able to achieve the savings of 5 to 15 percent over fee-for-service reported in the literature, these savings on care for low-income families would result in a 1 to 2 percent savings for the overall program. Achieving significant overall program savings from managed care will be difficult without enrolling the costly disabled and elderly populations. Most Medicaid dollars are spent on services to the elderly and disabled, but the experience with these populations in managed care is limited and the potential for savings is unknown.

The extent to which states will be able to achieve savings from managed care is also highly dependent on the current configuration of their Medicaid programs. States that have a heavier share of their Medicaid dollars in long-term care services will be less able to achieve significant savings than those with a larger share of spending in acute care services where managed care has its greatest potential for savings. As shown in Figure 11, there is substantial variation across states in the level of spending related to acute versus long-term care services.

Pressure on Medicaid from Low-Income Medicare Beneficiaries

In recent years, Medicaid has also been pressed to expand the assistance offered to low-income Medicare beneficiaries. Today, nearly 4 million low-income disabled and elderly Medicare beneficiaries rely on Medicaid to pay the premium and cost-sharing obligations under Medicare and provide benefits that Medicare does not cover, most notably prescription drugs and long-term care. In 1995, Medicare's Part B premium is $533.20 per year and cost-sharing requirements are $716 for a hospital stay, a $100 deductible for physician services, and 20 percent cost-sharing for physician and other medical care.

In essence, Medicaid makes Medicare work for the low-income elderly and disabled by reducing their financial barriers to care under Medicare. However, providing this coverage to the dual beneficiaries of Medicare and Medicaid imposes financial obligations on state Medicaid programs. Increases in Medicare's obligations on beneficiaries translates to higher Medicaid costs to finance these payments, but states have no control over the level of Medicare premiums and cost-sharing. Many states argue it should be the responsibility of the federal government, not Medicaid, to pick up the additional cost to low-income beneficiaries when costs to Medicare beneficiaries increase.

In addition to its role supplementing Medicare, Medicaid is also under pressure because it provides the only public source of financing for long-term institutional care for individuals with severe physical and cognitive limitations. Medicaid pays for half of all nursing home care and about 20 percent of long-term home and community-based care. In the absence of adequate private financing alternatives, setting appropriate limits on Medicaid's availability to help families and individuals with long-term care will continue to be a source of tension in program policy and spending.

CHALLENGES FOR MEDICAID'S FUTURE

Since its enactment in 1965, Medicaid has improved access to health care for the poor, pioneered innovations in health care delivery and community-based long-term care services, and stood alone as the primary source of financial assistance for long-term care. Today, Medicaid continues to play a critical role in providing acute and long-term care services to our nation's most vulnerable people, but its widening safety net responsibilities and spending growth are straining both federal and state budgets. The most critical issue facing Medicaid today is how this safety net program can best be structured to meet the needs of low-income Americans at the most reasonable cost to the federal and state governments.

As it enters its thirtieth year, Medicaid is at a critical juncture. In its role as a medical safety net, Medicaid is today financing care for over 36 million of the poorest, sickest, and most disabled Americans at a cost of over $159 billion to federal and state governments. But, Medicaid has been a victim of its own success. While Medicaid was broadening its reach in providing health insurance to the poor and becoming the mainstay of financing for long-term care, spending was rising rapidly, raising new questions about the ability of the federal and state governments to sustain such growth.

Today, the Congress is proposing to curb federal Medicaid spending to realize savings of $184 billion from projected federal spending between 1996 and 2002. This would amount to an 18 percent reduction in federal support for Medicaid over this period. As shown in Figure 12, the growth limits would have a wedge effect with the largest share of the reductions occurring in the last two years.

In addition, proposals are being discussed that would dramatically alter the program structure and beneficiary protections by replacing the current entitlement program with a block grant to the states. Instead of guaranteeing insurance coverage, protection for nursing home residents, and federal financing for all individuals who meet Medicaid's eligibility criteria, a block grant would provide states with federal funds and the flexibility to decide how those funds can be used. Under the proposals being discussed, states would gain discretion over the scope and design of the program, but lose unrestricted federal matching payments because federal payments to the states would be capped. The full impact of such proposals is highly dependent on the level of cuts in federal funding, the degree of flexibility given to individual states, and ultimately on the decisions made by individual states which are difficult to predict.

The reduction in federal Medicaid spending coupled with the proposed end to the entitlement nature of Medicaid are likely to result in significant changes in the scope of coverage of the poor and the way in which their care is organized and financed. Because states have differing economic situations and the current Medicaid program varies in size and scope across the states, the impact of the changes is difficult to predict, but would certainly affect states differently. As shown in Figures 13 and 14, states have different patterns of Medicaid expenditures per poor person as well as very different growth rates in expenditures per beneficiary. A block grant with a federal rate of increase limit on funding would fix these differences in place and make it difficult for states to accommodate future growth in the program.

The outcome of the policy debate over Medicaid's future is obviously of great import to the states, the low-income people who now rely on Medicaid for health and long-term care services, and the providers that serve them. There are no simple solutions to reducing the cost of providing care to the over 36 million Americans who now depend on Medicaid or the millions more who are uninsured and fall just beyond its reach.

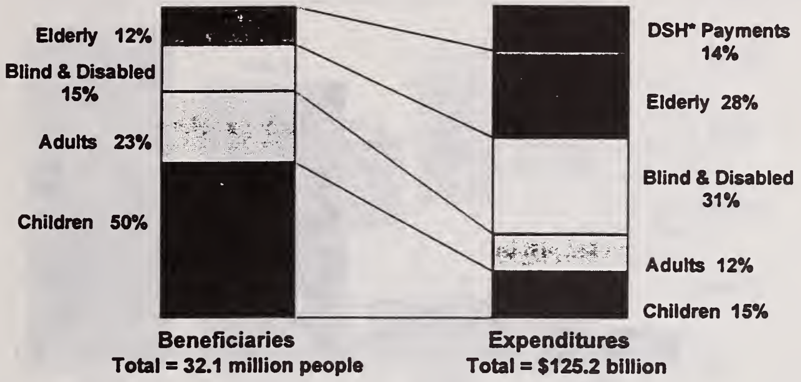
The policy dilemma at both the federal and state levels is how to restrain the rising cost of care for the vulnerable populations served by Medicaid without compromising the vital safety net role of the program in ensuring access to essential health services for the needy. In implementing solutions to meet the crises of today, it is important not to undo the progress Medicaid has made in providing health care for tens of millions of low-income and elderly and disabled Americans.

Thank you for the opportunity to testify today. I welcome your questions.

Attachment.

Figure 1

Medicaid Beneficiaries and Expenditures by Enrollment Group, 1993



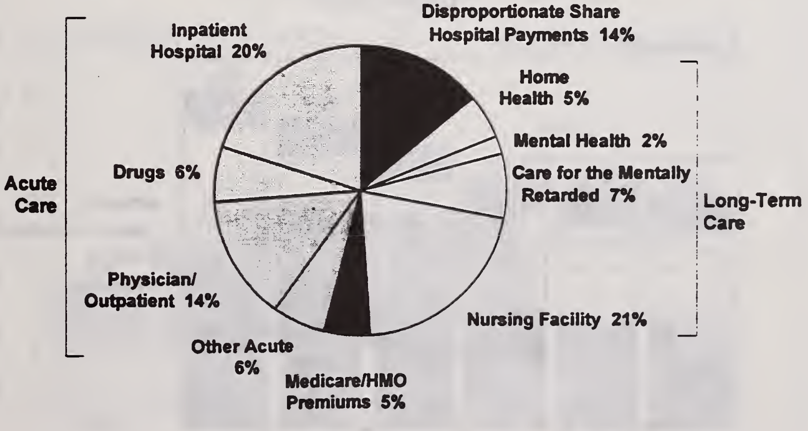
* Disproportionate share hospital

SOURCE: Urban Institute analysis of HCFA data, 1994.

The Kaiser Commission on
THE FUTURE OF MEDICAID

Figure 2

Medicaid Expenditures by Type of Service, 1993



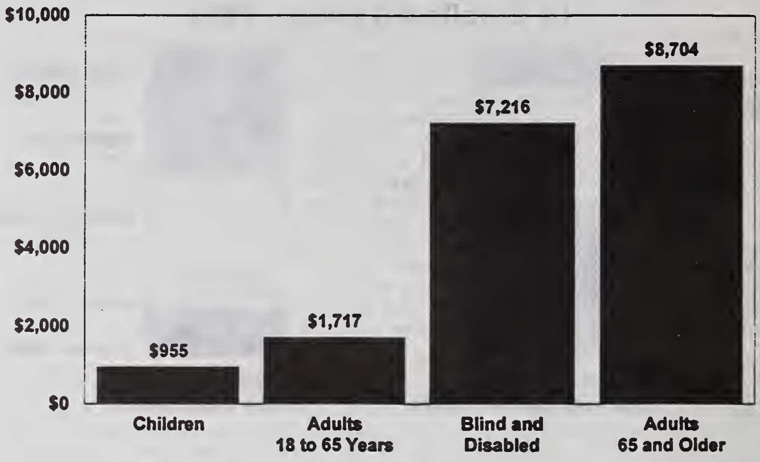
Total = $125.2 billion

SOURCE: Urban Institute analysis of HCFA data, 1994.

The Kaiser Commission on
THE FUTURE OF MEDICAID

Figure 3

Medicaid Expenditures Per Enrollee, 1993

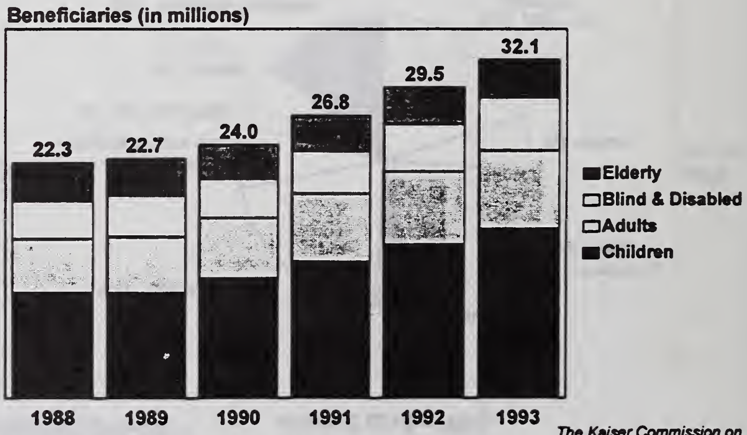


Note: The totals per enrollee do not include disproportionate share payments to hospitals.
SOURCE: Winterbottom, Liska, and Obermaier, 1994

The Kaiser Commission on
THE FUTURE OF MEDICAID

Figure 4

Medicaid Beneficiary Growth by Enrollment Group, 1988-1993

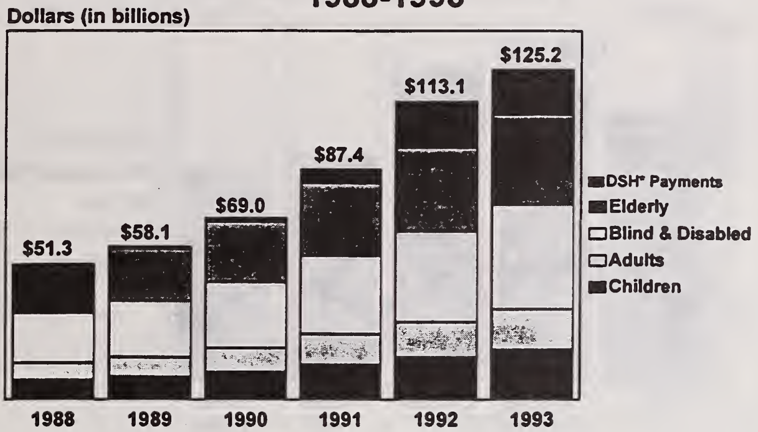


SOURCE: Urban Institute analysis of HCFA data, 1994.

The Kaiser Commission on
THE FUTURE OF MEDICAID

Figure 5

Medicaid Spending by Enrollment Group, 1988-1993



* Disproportionate share hospital

SOURCE: Urban Institute analysis of HFCA data, 1994.

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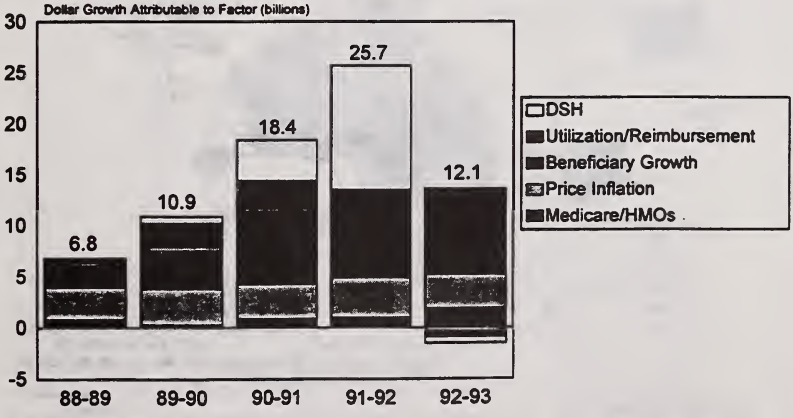
THE FUTURE OF MEDICAID

Figure 6

Decomposition of Medicaid Expenditures by Year and Growth Factor



Source: The Urban Institute calculations based on HCFA 64 data, 1995.

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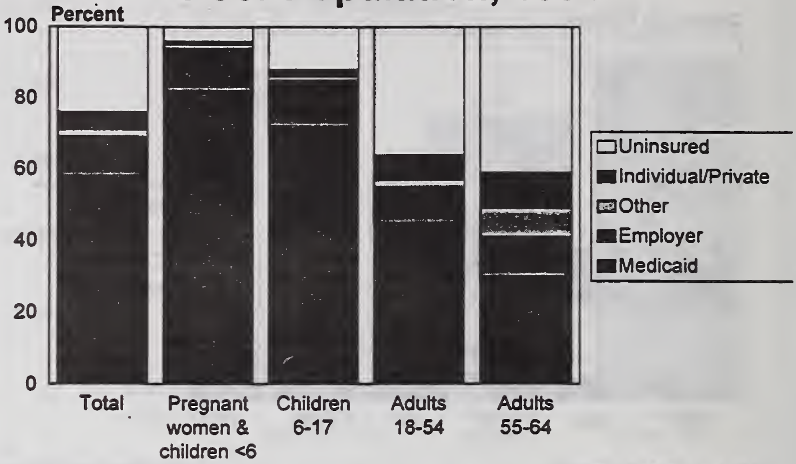
Figure 7

Insurance Coverage of the Poor Population, 1994



SOURCE: Urban Institute estimates, 1994

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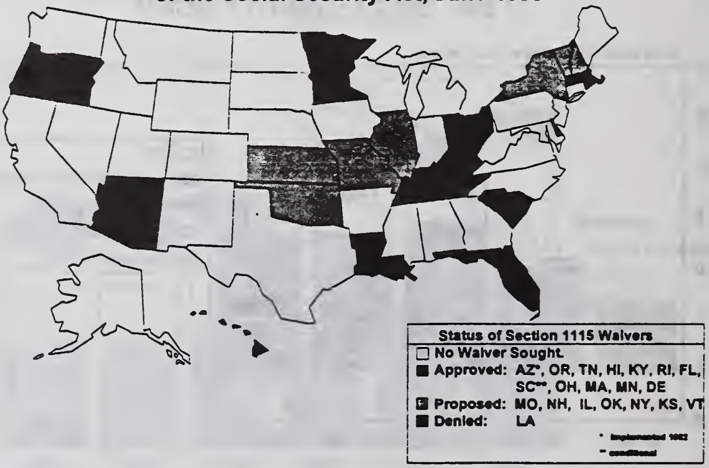
Figure 8

Statewide Medicaid Demonstrations Under Section 1115 of the Social Security Act, June 1995


Status of Section 1115 Waivers
☐ No Waiver Sought
■ Approved: AZ*, OR, TN, HI, KY, RI, FL, SC**, OH, MA, MN, DE
▨ Proposed: MO, NH, IL, OK, NY, KS, VT
■ Denied: LA
* implemented 1982
** conditional

SOURCE: The George Washington University Center for Health Policy Research, 1995.

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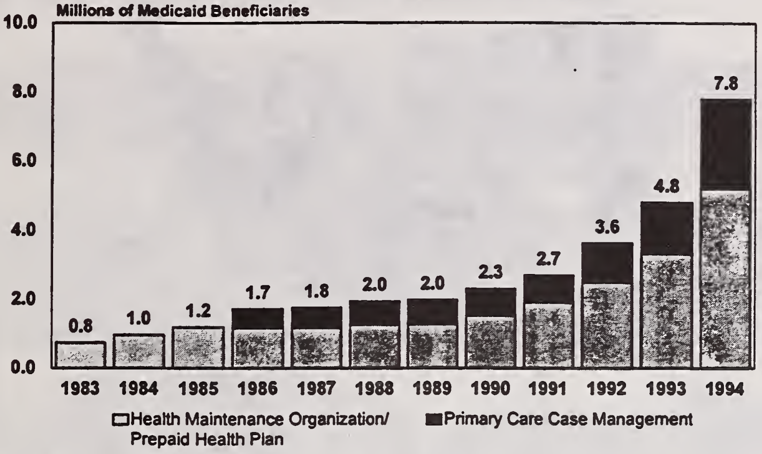
Figure 9

Growth in Medicaid Managed Care Enrollment, 1983-1994



SOURCE: Health Care Financing Administration, 1992 and Health Care Financing Administration, 1994.

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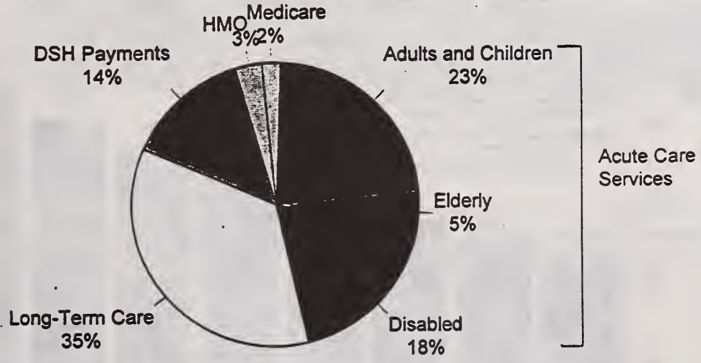
Figure 10

Medicaid Spending by Service, 1993



Total Expenditures = $125.2 Billion

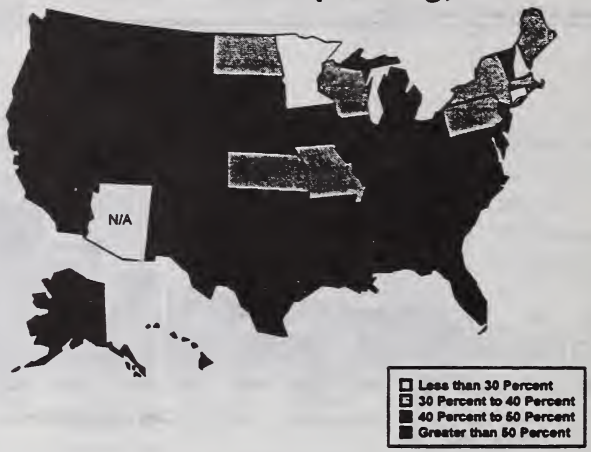
Note: "HMO" represents payments for Medicaid beneficiaries enrolled in managed care. "Medicare" represents payments for Medicare Part B premiums and co-payments for low-income elderly.

SOURCE: The Urban Institute analysis of HCFA data.

The Kaiser Commission on
THE FUTURE OF MEDICAID

Figure 11

Medicaid Acute Care Spending as a Percent of Total Medicaid Spending, 1993

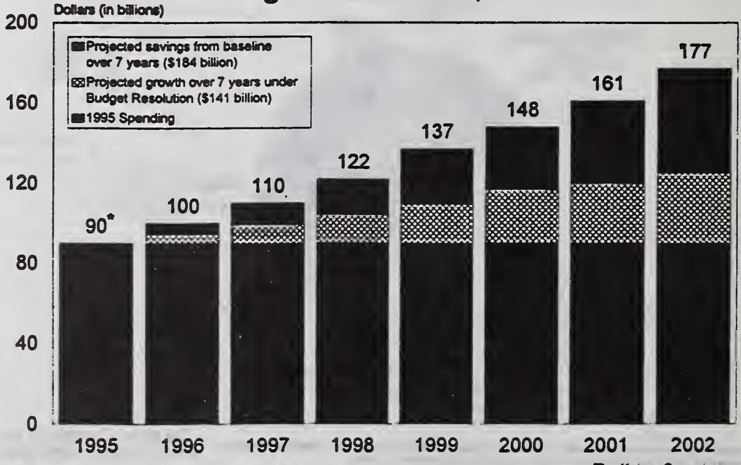

N/A
☐ Less than 30 Percent
▨ 30 Percent to 40 Percent
■ 40 Percent to 50 Percent
■ Greater than 50 Percent

SOURCE: Urban Institute analysis of HCFA data, 1994

The Kaiser Commission on
THE FUTURE OF MEDICAID

Figure 12

Projected Federal Medicaid Spending Under Budget Resolution, 1996-2002



* The 1995 Budget Resolution uses an estimate of $89 billion for 1995 spending.
Source: CBO 1995; 1995 Budget Resolution.

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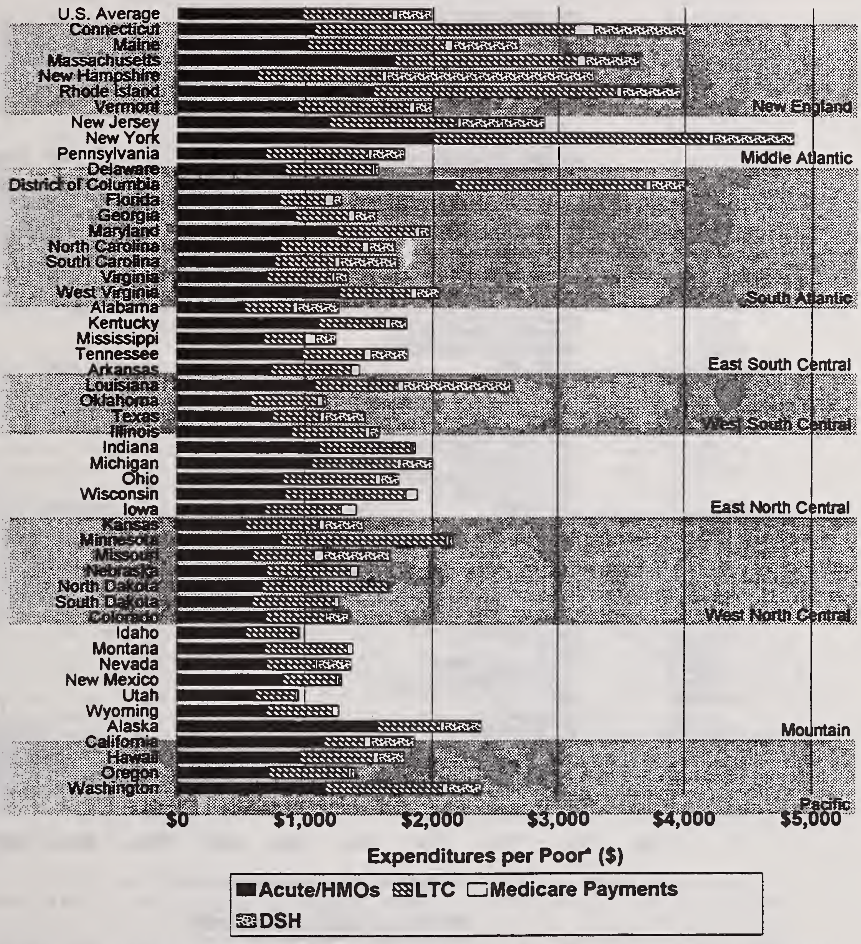
Figure 13

Medicaid Expenditures per Poor* Person

By state, census region, and type of service, 1993

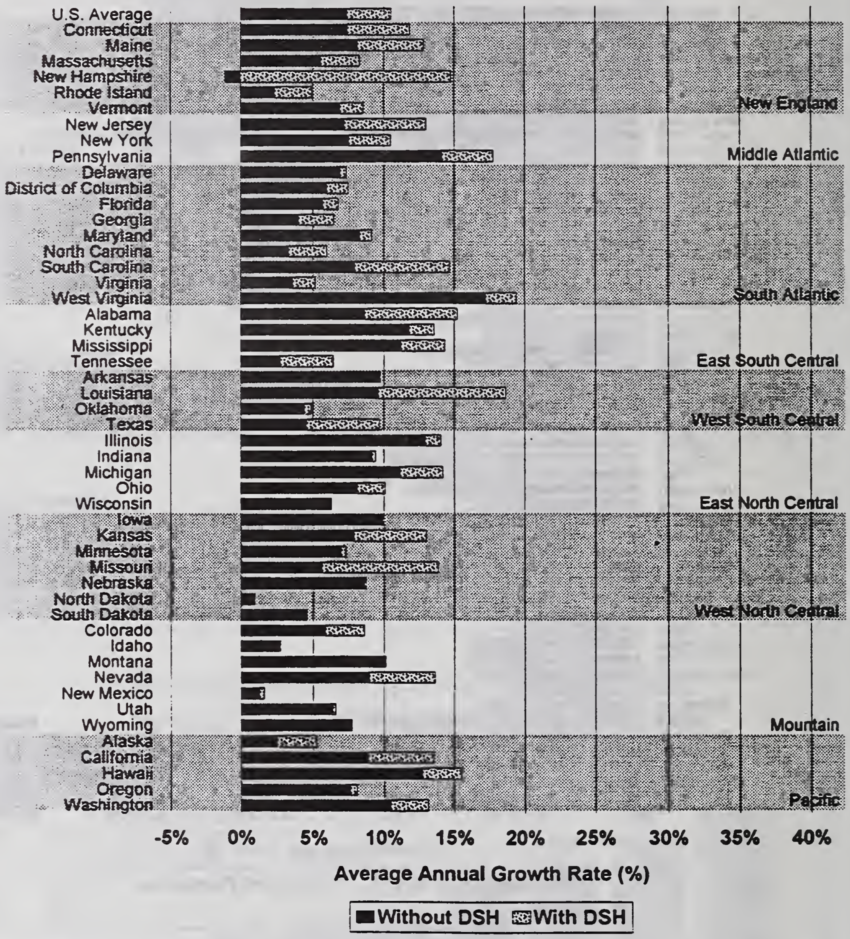


SOURCE. The Urban Institute, prepared for the Kaiser Commission on the Future of Medicaid. Based on the HCFA 64 and the 1991-1993 March Current Population Surveys. 1993 population numbers are estimated. Expenditures do not include Arizona, U.S. Territories, accounting adjustments, or administrative costs. *Poor defined as the number of individuals below 150% of poverty.

Figure 14

Growth in Medicaid Expenditures per Beneficiary

With and w/out disproportionate share payments (DSH), 1988-93



SOURCE The Urban Institute, prepared for the Kaiser Commission on the Future of Medicaid. Based on the HCFA 64 and HCFA 2082. Does not include Arizona, U.S. Territories, accounting adjustments, or administrative costs.

PREPARED STATEMENT OF WILLIAM J. SCANLON

Mr. Chairman and Members of the Committee:

I am pleased to be here today to testify on state flexibility to pursue innovative restructurings of their Medicaid programs. This hearing comes at a time when the Congress is searching for ways to slow down Medicaid spending growth. In response, many governors are asking the Congress for authority to initiate cost-conscious innovations without the burden of seeking federal waivers.

The urgency underlying cost containment in the $142 billion Medicaid program is readily apparent. Between 1985 and 1993, Medicaid costs tripled and the number of beneficiaries increased by over 50 percent. Medicaid growth outpaces that of most major items in the federal budget, including Medicare, and without modification, spending is likely to double in the next 5 to 7 years. It is also the fastest growing component of most state budgets at a time when governors and legislatures are under financial constraints and many are looking for ways to provide care to their uninsured populations.

My comments today will focus on (1) existing authority to waive Medicaid managed care restrictions, (2) the purpose behind such restrictions and the need for oversight in their absence, and (3) our concerns about the impact of recently approved waivers on federal Medicaid expenditures. This testimony is based on the reports we have issued over the years on states' experience with Medicaid managed care and on our recent work on statewide demonstration waivers under section 1115 of the Social Security Act. Appendix I contains a list of related GAO reports.

In brief, requiring states to obtain waivers to broaden use of managed care may hamper their efforts to aggressively pursue cost-containment strategies. At the same time, because current program restrictions on managed care were designed to reinforce quality assurance, their absence requires the substitution of appropriate and adequate mechanisms to protect both Medicaid beneficiaries and federal dollars. Finally, the reinvestment of managed care savings to expand Medicaid coverage to several million additional individuals suggests the need for up-front consultation with the Congress because of (1) the heavier financial burden such 1115 waivers may place on the federal government and (2) the issue of whether the U.S. Treasury should benefit from those savings.

OVERVIEW OF MEDICAID

Financed jointly by the federal government and the states, Medicaid is the nation's health care lifeline for 33 million low-income Americans--primarily women and children, but also the aged, blind, and disabled. By far, the majority of Medicaid funds are spent on behalf of this latter group. Although they represent only slightly more than a quarter of all beneficiaries, the aged, blind, and disabled incurred about 66 percent of Medicaid's expenditures in 1993. The per person cost of these beneficiaries was four times more than the cost for women and other adults and seven times more than the cost for children. Moreover, long-term care spending for the aged, blind, and disabled--primarily nursing home care dollars--totaled just over one-third of overall Medicaid spending, only about 10 percent less than total expenditures on physician, hospital, and other acute care services.

In reality, Medicaid is not 1 but rather 56 separate programs that differ dramatically across states.[1] While federal statute mandates who at a minimum must be included as eligible for coverage and the broad categories of services that must be provided, each participating state designs and administers its own program within federal guidelines by (1) setting some income and asset eligibility requirements; (2) selecting optional groups and services to cover; (3) determining the scope of mandatory and optional services, for example, by limiting the number of covered hospital days per year; and (4) establishing the methods and amounts of provider payments. As a result of this flexibility, Medicaid eligibility and access to services vary considerably across states.

Currently, states must seek a federal waiver to diverge from the norm outlined in the Medicaid statute[2]--a statute whose fundamental reliance on fee-for-service and institutional providers has been changed little since the program's inception. Waivers are typically granted for between 2 to 5 years and states must reapply to continue their program innovations. Obtaining approval may take many months. Two waiver authorities have been widely used by states. Under section 1915(b) of the Social Security Act, more than 40 states require some portion of their Medicaid population to enroll in a managed care arrangement. Increasingly, states are seeking even greater flexibility in implementing statewide Medicaid managed care programs and are asking for authority to use potential savings to expand coverage to individuals not normally eligible for Medicaid. The degree of flexibility being sought is only available through demonstration waiver authority established by section 1115 of the act.

1115 WAIVERS PROVIDE THE MOST MANAGED CARE FLEXIBILITY

The Medicaid statute--drafted in the mid-1960s--reflects a bias toward the state-of-the-art health care delivery system of that era. However, that system has evolved considerably. Unrestricted choice of providers reimbursed on a fee-for-service basis has been superseded in importance by a continuum of managed care delivery systems.[3] In 1993, about 60 percent of individuals with health benefits sponsored by large employers were enrolled in some type of managed care plan--up dramatically from a decade ago. In contrast during that same year and prior to the implementation of recent statewide 1115 Medicaid waivers, only 14 percent of Medicaid recipients--primarily women and children--were enrolled in managed care. To mandate enrollment of Medicaid recipients in a managed care plan, a state must either obtain a 1915(b) program waiver or an 1115 demonstration waiver. Section 1115 waivers provide a state the most flexibility in implementing a managed care program.

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[1] All 50 states plus the District of Columbia, Puerto Rico, and the four U.S. territories have Medicaid programs.

[2] Title XIX of the Social Security Act.

While states need no special authority to encourage voluntary enrollment in a managed care plan, the beneficiary must have a choice of fee-for-service and be allowed to disenroll at will. Two other options require a federal waiver under section 1915(b):

-- mandatory enrollment in multiple HMO systems with disenrollment allowed on a monthly basis (or every 6 months if an HMO meets certain federal requirements), and

-- mandatory enrollment in a physician gatekeeper system where the physician is either paid partially on a per patient basis or reimbursed under fee-for-service.

Section 1915(b) authority has been widely used since its enactment in 1981. As of March 1995, 42 states operated 1915(b) waiver programs. These programs were primarily substate and involved physician gatekeepers rather than HMOs. To receive a waiver, a state must show that managed care will cost no more than its fee-for-service program, will not diminish access to adequate quality care, and will not adversely affect access to emergency care or family planning services. Authority to operate a 1915(b) waiver program may be renewed every 2 years.

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[3] Though no commonly accepted definition exists for the term "managed care," a number of features are typically associated with it: (1) provider networks with explicit criteria for selection, (2) alternative payment methods and rates that often shift some financial risk to providers, and (3) utilization controls over hospital and specialist physician services. Despite the confusing nomenclature used to distinguish a variety of managed care plans--HMO, PPO, PCCM--most include one or more of these common cost control features. Health maintenance organizations (HMO), the most tightly controlled type of managed care plans, require patients to use affiliated physicians who may be salaried, paid on a per capita basis (often referred to as "capitated"), or be reimbursed for each service. Typically, a patient's care, especially referrals to specialists and hospitalization, is coordinated by a primary care physician--often called a "gatekeeper." Preferred provider organizations provide enrollees with a financial incentive--lower cost sharing ("copays")--to receive care from a network of providers that are normally reimbursed at a discounted rate. Finally, many state Medicaid programs have conducted substate experiments using a primary care case management approach in which physician gatekeepers must provide authorization to see a specialist or obtain hospital care. Gatekeeper physicians may be partially capitated or paid for each service delivered.

Despite the availability of 1915(b) waivers, state officials believe that a number of provisions in the Medicaid statute inhibit implementation of broader managed care programs, particularly those involving HMO-style capitated plans. These provisions--the so-called 75/25-percent rule and the beneficiary enrollment lock-in provision--can only be waived under section 1115. Appendix I delineates the additional flexibility available under an 1115 waiver compared with 1915(b) waivers.

In keeping with the designation "demonstration," 1115 waivers have typically been granted for research purposes. Applications must include a formal research methodology and provide for an independent evaluation. Section 1115 waivers may be granted at the discretion of the Secretary of Health and Human Services for any demonstration project likely to assist in promoting the objectives of Medicaid. They are generally granted for between 3 and 5 years.

Prior to 1993, use of 1115 waivers to establish mandatory Medicaid managed care programs was very limited.[4] However, to deal with pressures to contain costs while confronting the problem of the uninsured, a number of states have turned to section 1115 demonstration waivers. In an ambitious experiment, the Clinton administration has approved 10 statewide 1115 demonstrations to determine if the Medicaid program can actually save money while simultaneously expanding coverage to several million new beneficiaries. Nine more states have pending waivers, including New York, and other applications are anticipated. Approval of 1115 demonstration waivers has been facilitated by the administration's 1993 commitment to streamline the review process and to be more flexible in assessing whether waivers increase federal costs.

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[4] Two waivers were granted in 1982 to Arizona and Minnesota. Heretofore, Arizona had not participated in Medicaid. While Arizona established a statewide mandatory program under its waiver, the Minnesota program only operated in the Minneapolis metropolitan area and one rural county.

OVERSIGHT NEEDED FOR TRANSITION TO MANAGED CARE

Medicaid's restrictions on states' use of managed care reflect historical concerns over quality. In the 1970s, reports on quality of care problems in Medicaid HMOs--the predominant form of managed care at the time--prompted the Congress to enact certain provisions intended to ensure that health plans provide public clients the same standard of care available to private clients. The stipulation that more than 25 percent of a health plan's total enrollment consist of private-paying patients was intended as a proxy for quality since such patients presumably have a choice of health plans and can vote with their feet. A second provision allowing Medicaid beneficiaries to terminate enrollment in a health plan at almost any time aims to provide them a similar capacity to express dissatisfaction over the provision of care.

Beneficiary protections are essential because of the financial incentive to underserve inherent in managed care plans that are paid, and are themselves paying providers, on a per capita rather than on a per service basis. Large private sector employers have recognized the importance of adequate oversight and are demanding strong quality assurance systems.

The Health Care Financing Administration (HCFA) also seems cognizant of the need for adequate oversight. In agreeing to waive some of the traditional requirements aimed at ensuring managed care quality, it has required states under the terms and conditions of section 1115 waivers to operate alternative quality assurance systems and to collect medical encounter data that allow service use and access to be monitored. States can indicate their commitment by the resources and effort they devote to implementing and operating their oversight functions.

Our reviews of Oregon's experience with both a 1915(b) substate waiver and its recently initiated statewide 1115 demonstration suggest a significant commitment to maintaining adequate oversight. Oregon implemented its 1115 Medicaid demonstration only after a considerable planning and design effort. Its implementation planning began more than 5 years ago and included numerous community meetings and consultation with providers--some of whom were already participating in its substate managed care program dating from the mid-1980s. According to officials, lessons learned from this earlier effort have helped the state to implement its more ambitious statewide managed care program more effectively. As part of its program to enroll the aged, blind, and disabled, the state worked with advocacy groups and consumers to develop additional safeguards for these more vulnerable populations.

Oregon has implemented an array of safeguards designed to ensure access and quality. It requires plans to limit the financial pressure on any one provider in an effort to guard against underservice. The state also adopted an extensive quality assurance program that requires plans to maintain internal safeguards and to contract annually for an independent examination of medical records by a physician review organization. Oregon uses client satisfaction and disenrollment surveys and a grievance procedure to further monitor quality. Finally, for the disabled and other persons with serious illnesses, it requires health plans to provide "exceptional needs care coordinators" and makes special ombudsmen available to handle grievances.

SOME STATES' 1115 WAIVERS COULD INCREASE FEDERAL SPENDING

In approving recent statewide 1115 Medicaid waivers, the administration has entered into 5-year budget commitments that allow each state to reinvest managed care savings and to redirect other funds in order to expand coverage to currently uninsured individuals. Compared with expenditure trends for the pre-demonstration programs, waiver states declare that the net result will be lower costs--even though managed care savings are being reinvested. The administration has given the federal stamp of "budget neutral" to all approved 1115 demonstrations, asserting that they will cost no more than continuation of the smaller pre-waiver programs. We disagree.

Three of four approved 1115 waivers we examined in detail provide access to additional federal Medicaid funds to help finance state coverage expansion goals. Only Tennessee's demonstration costs no more than the continuation of its smaller, pre-waiver program and, in fact, should result in savings. The spending limits for approved waivers in Oregon, Hawaii, and Florida are not budget neutral and could increase federal Medicaid expenditures. Overall, net federal spending in these four states could potentially exceed what Medicaid program expenditures would have been by several hundred million dollars over the duration of the waiver programs. Though the net additional federal funding is small in relation to demonstration spending allowed under federal expenditure caps, federal Medicaid costs could grow significantly if the administration shows a similar flexibility in reviewing additional waivers.

We believe that the granting of additional 1115 waivers merits further congressional scrutiny. Even if the proposed demonstrations did not require new federal dollars, the administration's approval of coverage expansions means that anticipated Medicaid savings will not be available to reduce federal spending. At issue is whether the U.S. Treasury should benefit from these savings and whether eligibility should be made available for new groups only after congressional debate and legislative action. Furthermore, Congress may face two equally unattractive alternatives if 1115 demonstrations exceed federal spending caps: (1) increasing federal funding or (2) relying on states to reduce benefits or deny coverage to hundreds of thousands of people newly enrolled under the waivers. Consequently, we believe that demonstration waivers granted for a limited period may be a shortsighted approach to reducing states' uninsured populations.

CONCLUSIONS

Over 33 million low-income women, children, aged, blind, and disabled Americans depend upon health care made possible by the Medicaid program. However, the program's double-digit spending growth rate imperils efforts to bring the federal budget deficit under control. Consistent with the Committee's interest in constraining federal spending, states believe they need the flexibility to manage their own programs. Requiring states to obtain waiver approval in order to aggressively pursue managed care strategies may hamper their cost-containment efforts. Yet, because current program restrictions on managed care were designed to reinforce quality assurance, in their absence, continuous oversight of managed care systems is required to protect both Medicaid beneficiaries from inappropriate denial of care and federal dollars from payment abuses. Finally, the potential for increased federal spending under future statewide demonstrations suggests the need for greater consultation with the Congress.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or the other Committee Members may have.

For more information on this testimony, please call William J. Scanlon, Associate Director, at (202) 512-4561. Other major contributors included Walter Ochinko and Richard Jensen.

COMPARISON OF MANAGED CARE FLEXIBILITY AVAILABLE UNDER 1915(B) VERSUS 1115 WAIVERS

1915(b) program waivers	1115 demonstration waivers
HMOs must still the meet federal requirement for more than 25 percent private enrollment	HMOs may enroll Medicaid patients exclusively
Full range of mandatory services must be offered	Benefits package may be modified
Enrollment lock-in limited to 1 month[a]	Enrollment lock-in may be extended to 12 months
No restrictions on access to family planning providers	Access to family planning providers may be restricted

[a] The lock-in is 6 months for an HMO meeting certain federal qualifications.

RELATED GAO PRODUCTS

Medicaid Managed Care: More Competition and Oversight Would Improve California's Expansion Plan (GAO/HEHS-95-87, April 28, 1995).

Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/HEHS-95-122, April 4, 1995).

Medicaid: Restructuring Approaches Leave Many Questions (GAO/HEHS-95-103, April 4, 1995).

Medicaid: Experience With State Waivers to Promote Cost Control and Access to Care (GAO/T-HEHS-95-115, March 23, 1995).

Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs (GAO/HEHS-94-167, Aug. 11, 1994).

Medicaid Managed Care: Healthy Moms, Healthy Kids--A New Program for Chicago (GAO/HRD-93-121, Sept. 7, 1993).

Medicaid: HealthPASS--An Evaluation of a Managed Care Program for Certain Philadelphia Recipients (GAO/HRD-93-67, May 7, 1993).

Medicaid: States Turn to Managed Care to Improve Access and Control Costs (GAO/HRD-93-46. March 17, 1993).

Medicaid: Factors to Consider in Managed Care Programs (GAO/T-HRD-92-43, June 29, 1992).

Medicaid: Oregon's Managed Care Program and Implications for Expansions (GAO/HRD-92-89, June 19, 1992).

Medicaid: Factors to Consider in Expanding Managed Care Programs (GAO/T-HRD-92-26, April 10, 1992).

Managed Care: Oregon Program Appears Successful but Expansion Should Be Implemented Cautiously (GAO/T-HRD-91-48, Sept. 16, 1991).

Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area (GAO/HRD-90-81, August 27, 1990).

Medicaid: Lessons Learned from Arizona's Prepaid Program (GAO-HRD-87-14, March 6, 1987).

Arizona Medicaid: Nondisclosure of Ownership Information by Health Plans (GAO/HRD-86-10, Nov. 22, 1985).

Prepared Statement of Bruce Siegel, M.D., M.P.H.

I. INTRODUCTION

Thank you, Mr. Chairman and other distinguished members of the Committee for inviting me to testify before you today. My name is Dr. Bruce Siegel and I am President of the New York City Health and Hospitals Corporation (HHC), the largest public hospital system in the nation. I am here to share my perspective on the critically important issue of how we can best reshape the Medicaid program in a way that will allow us to achieve considerable cost savings while still maintaining the ability to meet the health needs of our nation's poorest citizens. Although I come before you today not representing any organization or interest group other than the hospital system I run, please keep in mind that my comments will likely reflect the sentiments of a great many of the nation's inner-city health care providers, both public and private, most of whom depend greatly on the Medicaid program to meet the health needs of their communities.

II. HHC AT A GLANCE

Before I begin, let me take a moment to tell you about the Corporation and the patients we serve. Throughout New York City, HHC operates 11 acute care hospitals, six large community health centers, five long-term care facilities, a growing network of community-based clinics, the Citywide Emergency Medical Service, and MetroPlus, HHC's Medicaid HMO. The Corporation employs approximately 43,000 people and has an annual operating budget of about $3.8 billion.

Because we operate in the City's most medically underserved areas, our patients tend to be the poorest, sickest and most vulnerable New Yorkers. For instance, we treat about 50% of the City's AIDS patients and 60% of patients who suffer from psychiatric disorders. Of these patients, a disproportionately high percentage have serious alcohol and substance abuse problems.

The Corporation also handles a tremendous percentage of the City's overall medical and public health care needs. We provide roughly 50% of the City's outpatient care, 20% of its inpatient care, and 40o of its emergency care. Last year, we delivered over 28,000 babies, admitted more than 200,000 patients, and handled over one million emergency room visits and nearly five million ambulatory care visits. Like other public hospitals around the country, we also provide such vital services as specialized trauma, burn, and neonatal intensive care that are relied upon by the entire community. And in keeping with our mission, HHC is one of the largest, if not the largest, providers of indigent care in the nation.

III. ADAPTING TO THE CHANGING HEALTH CARE CLIMATE

Before I offer some thoughts on where I think we need to head in the Medicaid debate, it would be helpful to first take a moment to describe for you some of the changes that HHC and other providers like us have undergone in recent years. Our nation's health care system is in the midst of a profound transformation. There are two principal factors driving this change. The first is the hard fiscal times upon which many state and local governments have fallen over the past few years. This is particularly true in New York, where both the State and New York City governments have had to close multi-billion dollar budget gaps in the past few years. The other factor that has accelerated the process of change is the rapid move to managed care. Again, this is true of New York where managed care penetration has increased swiftly and is now above the national average.

At HHC, the impact of these developments on our budget has been enormous. In FY95, HHC had to close a budget gap of $450 million. We were able to minimize the impact of these cuts on patient care and capitalize on the shift to managed care by organizing HHC into six vertically integrated health care networks. The way we plan is now based on an assessment of the strategic needs of our six networks, with an emphasis placed on how we can best position ourselves to compete in the new managed care arena. This new way of operating has already yielded many new efficiencies and millions of dollars in cost savings. In addition, HHC's HMO, MetroPlus, is now the fastest growing Medicaid HMO in the City and the second largest overall with more than 60,000 members.

Despite our considerable success at cutting costs and increasing our managed care market share, the immense fiscal pressure we're under has forced us to make a number of difficult reductions. For instance, we've downsized our workforce by over 6,200 FTEs in the past 15 months and we've taken well over 1,000 beds out of service over the same period. This fiscal year, we will have to absorb an additional S400 million in cuts as a result of the recently concluded State and City budget processes.

In order to deal with this new round of cuts, I've directed each of our facilities to implement plans to reduce their individual budgets by 25 percent.

IV. THE IMPORTANCE OF MEDICAID TO SAFETY-NET PROVIDERS

Now, as we shift our attention to Washington and the enormous budgetary challenges you face, I think it is important to understand that the cost-saving measures that you and your colleagues in the House are beginning to put forth will come on the heels of the greatest budget reductions that many health care providers have ever experienced. In the case of HHC, the cuts we've endured over the past two years are, by far, the largest in the Corporation's 25-year history. That is not to suggest that we don't understand Congress' desire to ultimately eliminate the federal budget deficit. But reductions in Medicaid must be made responsibly and should not fall disproportionately on safety-net providers like HHC that are least able to bear the brunt of another round of deep budget cuts.

The principal reason why we enter the current federal budget season with such concern is because so many of our patients are insured by Medicaid and Medicare. Indeed, we receive more than 80 percent of our revenue from these payors with 72 percent coming from Medicaid alone. As a result, HHC is also a major recipient of Disproportionate Share funding which recognizes our role in treating Medicaid and Medicare patients while also acknowledging the tremendous amount of care we render to those with no means to pay at all.

While we and other safety-net providers understand the need to absorb our fair share of pain in this year of fiscal austerity, we also know that there is a limit to how much we can cut before we'll no longer be able to offer many of the vital services we currently provide. A recent study released by the National Association of Public Hospitals modeled the impact of the Senate's initial budget proposal. The study estimates that HHC would lose about $940 million in the year 2002, which would represent roughly 28 percent of our Medicaid revenues and 13 percent of our total revenues for that year. Over the entire seven-year period, the study estimates that we would lose more than $3 billion in Medicaid revenues. These figures give us an idea of just how devastating reductions of this magnitude would be to providers that serve large numbers of Medicaid recipients.

V. MAKING THE BEST OF A DIFFICULT SITUATION

Although these initial estimates appear rather grim, I believe that there are a number of steps Congress can take to minimize the adverse impact of Medicaid reductions on safety-net providers. In particular, I urge you to consider the following areas:

- **Disproportionate Share Payments (DSH)**—Federally mandated DSH payments account for $500 million of HHC's annual revenue or 12 percent of our total funding. Designed to defray the costs of treating the uninsured and poor, DSH funds are what enables HHC to meet our safety-net mission of caring for the sickest and most vulnerable New Yorkers. Proposals to scale back or to eliminate DSH funding altogether would devastate hospitals like ours. Moreover, I believe the DSH program could be improved by targeting DSH payments exclusively to the highest volume providers of care to the poor. Such a restructuring would make the program more faithful to Congress' original intent while providing true safety-net providers with a needed measure of relief from impending reductions in other parts of the Medicaid program. Lastly, I would recommend a shift of the DSH program from a strictly inpatient basis to one that recognizes outpatient services as well. This would create a long overdue incentive to provide more care to the poor and indigent in ambulatory settings when medically appropriate.
- **Graduate Medical Education**—New York State, whose hospitals train 15 percent of all doctors-in-training, is the center for graduate medical education in the U.S. HHC plays an integral role in New York's proud teaching establishment. With the exception of the Veterans Administration system, we are the largest training ground in the nation, serving as the practice site for over 3,000 future physicians a year. Because we train so many residents and they comprise such an integral part of our physician workforce, our facilities depend greatly on the direct and indirect medical education payments we receive from the federal government. Any dramatic reductions in federal support for graduate medical education would not only have immediate financial effects, but would also severely disrupt the availability of the workforce needed to provide health care in our institutions.
- **Encourage the Expansion of Managed Care**—While the enrollment of Medicaid recipients into HMOs has increased steadily in recent years, there are

many barriers that have prevented more rapid expansion and the savings that could have been generated by such growth. That is why I recommend that Congress enact legislation that would promote Medicaid managed care by granting greater flexibility to the states while still maintaining the proper degree of federal oversight.

- **Ensure Fairness**—Regardless of whether the Congress decides to pursue block grants, capped entitlements, a more rapid expansion of managed care, or some combination of these or other alternatives, it is imperative that Medicaid be reformed evenly and fairly. Congress should not endeavor to embark on a massive redistribution of Medicaid funds that would shift support from state to state or from region to region. To those who question New York for the amount it spends on Medicaid, I would simply point out that there are a host of very sound reasons which explain why our state's program is as costly as it is. First and foremost, New York spends a lot on Medicaid, but much of the money we spend is our own, not federal money. This is a reflection of New York's historic commitment to caring for its neediest citizens and of the fact that, along with ten other states, New York has the lowest federal matching rate in the nation. Specifically, each Medicaid dollar spent by the State and local governments in New York is matched by the federal government with one dollar in federal Medicaid spending. New York also must contend with such factors as high rates of violence, substance abuse, homelessness, and public health epidemics, all of which make our health care costs higher than those of other states. For instance, 20 percent of all AIDS cases nationwide are treated in New York City. New York hospitals also see more cases of tuberculosis than hospitals in the cities of Atlanta, Boston, Chicago, Houston, Los Angeles, Miami, and San Francisco combined. The reason I've enumerated these factors is to impress upon you how important it is to recognize the historic underpinnings of the individual Medicaid programs and how difficult and dangerous it would he to attempt to undo the decades-long partnerships that have evolved between the federal government and the states.

VI. CONCLUSION

Before I conclude, I want to thank you again for giving me the opportunity to describe the importance of Medicaid to our institutions and to the patients we serve. Public hospitals like ours are the health care safety net for the nation's poor. As you deliberate over the hard task of defining future Medicaid policy, I urge you to do it in a way that recognizes the importance of preserving a health care infrastructure capable of meeting the health needs of our sickest and most needy citizens. I'd now be glad to answer any questions that you might have.

Prepared Statement of Bruce C. Vladeck

Mr. Chairman and Members of the Committee: I welcome the opportunity to be here this morning to discuss State flexibility under the current Medicaid program and this Administration's efforts in expanding and assisting States in using that flexibility. The Medicaid program was conceived as a Federal/State partnership, and this Administration has made major strides in strengthening the relationship. Nonetheless, we recognize the need for additional work to build on this partnership.

Introduction

Before beginning our discussion about State flexibility, I would like to highlight some essential facts about the Medicaid program.

First, Medicaid's spending growth has moderated. A popular misconception holds that Medicaid is growing out of control, far faster than other parts of the health care sector. Chart 1 shows the contrary. In fact, the growth in Medicaid spending on a per person basis has not exceeded the growth in private health insurance since the period between 1989 and 1992. At that time, States used provider taxes combined with disproportionate share hospital payments as a means of increasing Federal matching funds.

Second, the lion's share of Medicaid spending is devoted to the aged and disabled. As chart 2 indicates, the aged and disabled represent 30 percent of Medicaid recipients and account for 70 percent of the spending.

Third, Medicaid is a critical safety net for a wide variety of populations with very diverse health needs. State Medicaid programs cover prenatal care for low and moderate-income pregnant women, health care for children, and long-term care for low-income senior citizens. They also provide a variety of rehabilitative and adaptive services for persons with disabilities, chronic care for individuals with special needs, and supplemental coverage for low-income Medicare beneficiaries. For many of these populations, whose disabling conditions or medical costs preclude them from purchasing insurance, Medicaid is the only system of care.

Chart 3 shows how Medicaid coverage increased between 1989 and 1994 while employer-based insurance declined. Although different populations are involved, Medicaid coverage increases have leveled the overall percent of uninsured and thereby maintained an essential balance in the cost shift to the private sector.

State Flexibility Under Current Law

Medicaid was enacted in 1965 to provide access to coverage for low-income Americans. Medicaid represented a consolidation of several Federal grant programs administered by the States. The nation's most vulnerable populations—low-income senior citizens, individuals with disabilities, and children—are Medicaid eligible in every State.

Nevertheless, the current Medicaid program is actually 56 different programs. The States have tailored their programs to meet the varying specific needs of their individual populations. The diversity across States' Medicaid programs is a direct result of the inherent flexibility of the program.

Flexibility in Coverage

The original Medicaid statute only required States' Medicaid programs to provide a set of five core benefits, including inpatient hospital services, outpatient services, physician services, laboratory and x-ray services, and skilled nursing home services. States could also cover any of ten optional benefits.

Over the past 30 years, Congress has added seven services to the list of required benefits and expanded the list of optional benefits that States may offer to include 30 services.

States use their flexibility to cover optional services to customize their Medicaid programs to serve the special needs of their vulnerable populations. For example, Utah provides 28 optional benefits to its Medicaid beneficiaries while Delaware offers 15 optional benefits. A few benefits, such as prescription drugs and clinic services, are offered by almost all the States and account for eight percent of all benefit spending. On average, the States cover 24 optional benefits. Only 44 percent of Medicaid service payments in 1993 (excluding DSH payments) was for mandatory services provided to mandatorily eligible individuals. Chart 4 shows that over 50 percent of the total Medicaid service payments was for optional services and populations elected by the States. Even these percentages may overstate mandatory spending, given States' discretion in establishing eligibility requirements for certain beneficiaries and because DSH spending is not included in the optional spending categories.

Flexibility in Determining Eligibility

States have flexibility in determining who is eligible for their Medicaid programs. The largest portion of the caseload are those on the Aid to Families with Dependent Children (AFDC) program. The eligibility standards for this program are directly determined by States.

The Social Security Act requires most States to cover those individuals who are eligible for the Supplemental Security Income (SSI) program. States may also extend Medicaid coverage to low-income families above the Federal minimum guidelines and to individuals with large medical expenses. The States use this flexibility to make their institutionalized aged and disabled populations eligible for Medicaid.

The Social Security Act requires States to cover pregnant women and children under age 6 up to 133 percent of the Federal poverty guideline. In addition, States must also phase-in coverage for all other children over age six born after September 30, 1983. Thirty-four States use Medicaid flexibility to expand coverage for pregnant women and children with family incomes beyond the Federal minimum guidelines. Twenty-seven of those States cover pregnant women and infants to at least 185 percent of the Federal poverty guidelines. In addition, States have unlimited flexibility to liberalize financial eligibility criteria for certain high-priority populations under the authority of section 1902(r)(2) of the Social Security Act. Under this provision, States are able to apply more liberal financial eligibility standards by disregarding certain income and/or assets.

Several States have used the authority of section 1902(r)(2) as a means of expanding eligibility for children beyond 185 percent of the Federal poverty level and accelerating the phase-in coverage for children below the poverty level. For example, both Delaware and West Virginia have used the 1902(r)(2) authority to cover all children under age 19 up to the Federal poverty level.

Flexibility in Service Delivery and Financing

States have additional flexibility to design their Medicaid programs through various program and research waivers.

Managed Care Programs

Under freedom-of-choice waivers, States can establish primary care case management programs, require Medicaid beneficiaries to choose among managed care plans, and selectively contract with hospitals, nursing facilities, or other providers. States use this flexibility to target coordinated and comprehensive managed care systems to their high-risk populations and to purchase services in a cost-effective manner.

States are taking full advantage of the flexibility to design managed care programs for their Medicaid populations. Approximately 8 million Medicaid beneficiaries are enrolled in managed care through about 80 freedom-of-choice programs and voluntary enrollment in 45 States.

States have also developed managed care programs to target a number of specific priorities. For example, the Kansas Primary Care Network (PCN), which was established in 1984, was one of the first managed care programs to provide physician case management to beneficiaries. Under this program, the State assigns each Medicaid beneficiary in the seven most populous counties to a physician case manager. The case manager is responsible for managing all of the recipient's health care. Over 30 percent of the State's Medicaid eligibles are now enrolled in this PCN program. State assessments have shown the program to be cost effective as well as providing better access to services for the participating Medicaid beneficiaries.

Similarly, Florida has developed MediPass, an extensive primary care case management program. The State pays MediPass primary care providers a $3 per member per month case management fee to coordinate care for their MediPass enrollees. These providers manage many of their patients' health needs, including specialty referrals, but continue to be paid on a fee-for-service basis for the health care services they provide.

Utah has developed a ground-breaking prepaid mental health program for Medicaid beneficiaries. The State contracts with three community mental health centers to provide inpatient and outpatient psychiatric and related physician services. The first year results indicate that contractors were able to reduce utilization of inpatient psychiatric services while increasing the percentage of eligibles served in their catchment areas.

Home and Community Based Services Programs

Home and community based services waivers give States the ability to establish home and community based care programs that provide services to beneficiaries in the community setting rather than in nursing homes and hospitals. Home and community based services programs allow States to manage care provided to the elderly and disabled populations in an efficient manner while increasing the consumer's satisfaction with the services provided.

States have made extensive use of this authority as well. Over 205 programs are now operating. Every state is currently serving developmentally disabled and aged individuals under a home and community based services program. States are also serving people with HIV/AIDS, those with traumatic head injury, and medically fragile children.

HCFA is actively involved in encouraging and assisting States in using this flexibility. Recently, Alaska officials requested HCFA assistance in developing their home and community based services program. Our staff went to Alaska and helped the State design four home and community based services programs to meet the unique needs of its citizens. The programs were quickly reviewed and approved. Other States are also increasingly seeing HCFA as a partner in the development of their programs.

Service Delivery and Financing Demonstrations

Medicaid's research and demonstration authority, section 1115 of the Social Security Act, gives States much broader opportunities to develop and test new and innovative ideas. States can use this authority to develop sub-state and statewide demonstrations of new approaches to health care financing and delivery.

This Administration has approved ten statewide section 1115 demonstrations. Several additional States have submitted proposals that are currently being reviewed. This Administration has approved more statewide demonstrations than any previous Administration. We have actively encouraged States to develop innovative reform demonstrations including managed care approaches working with the private sector and public health providers.

One of the first acts of this Administration was to approve the Oregon Reform Demonstration. The Oregon request, which was the first approval of a statewide demonstration in 10 years, had been denied by the previous Administration.

Since that point, innovative reform proposals have been approved in Hawaii, Tennessee, Rhode Island, Kentucky, Florida, Ohio, Massachusetts, Minnesota, and Delaware. These States are experimenting with new ways of financing and delivering essential health care. For example, Delaware has created seamless coverage for those below the Federal poverty level. Rhode Island is testing the effectiveness of extending family planning benefits and contracting with an FQHC-based managed care system.

In addition, the Administration has approved twenty-three smaller, more targeted section 1115 demonstrations. Some of these demonstrations provide preventive services to children, test extended family planning services, and establish alternative delivery systems.

For example, under the Iowa Drug Utilization Review Program, the State conducts on-line prospective drug utilization review. There are 250 pharmacies participating in the project either as randomized control or experimental entities.

Further, the multi-State Nursing Home Case-Mix and Quality Demonstration which is operating in Kansas, Maine, Mississippi, New York, South Dakota, and Texas, will test a combined Medicare and Medicaid nursing home payment and quality monitoring system. This system will significantly enhance the quality assurance process in nursing facilities.

Flexibility in Program Administration

States also have flexibility in many aspects of program administration. States have considerable flexibility in establishing provider participation criteria. Certification requirements for institutions such as hospitals and intermediate care facilities for the mentally retarded, physician qualification requirements, and requirements for other providers are determined primarily by the States.

Similarly, States have latitude in setting provider payment rates. Although the Boren Amendment and Medicare accounting principles provide broad lower and upper bounds with respect to payments for hospitals and nursing homes, States have flexibility to establish payment rates for these providers. States have still greater flexibility for other types of providers.

Another area in which States have flexibility is targeted case management. States use the Medicaid program to coordinate not only medical services but a range of social, educational, housing, or other services for Medicaid beneficiaries. States have the ability to use case management for as many segments of the Medicaid population as they believe would benefit from such coordination.

For example, States have established programs to coordinate the service needs of mentally retarded individuals, the mentally ill, individuals with HIV/AIDs, high-risk pregnant women, and at-risk children. In each case, the State is afforded the flexibility to define the level of service coordination provided, the target group, provider qualifications, level of payment, and any limits on the scope of services. This has enabled States to develop individualized plans of care for their most vulnerable citizens that weave together a tapestry of support from the diverse threads of Federal, State, local, and private resources.

With HCFA cooperation and assistance, many States are collaborating with various health-related and community organizations to design and implement programs that meet a comprehensive range of health needs of children. Because children's health is frequently affected by a number of socioeconomic conditions such as poverty, substance abuse, and fragmented health resources, no single agency or program can address all of their needs. Increasingly, communities are using public/private arrangements to develop integrated services networks. These networks disseminate information and serve as referral links between women and children in the community and the State's Medicaid, Maternal & Child Health, Women Infants & Children, and primary care programs.

Further, States have pursued a wide range of administrative and programmatic innovations. HCFA has encouraged and supported State program improvements, including:

- Introducing magnetic-strip cards to provide immediate access to information about eligibility and third-party liability; and
- Implementing automated drug utilization review to control fraud and improve the quality of pharmacy services.

Improving the Medicaid Program

As you know, the President recently suggested a number of ideas for enhancing the Federal-State partnership and controlling Medicaid costs. The President proposes a combination of policies to expand State flexibility and reduce the growth of Federal Medicaid spending. This combination includes expanding managed care, reducing and better targeting Federal payments for hospitals that serve a high proportion of low-income people, and limiting the growth in Federal Medicaid payments to States for each beneficiary. I believe these strategies represent the right approach to improving the Medicaid program.

We believe the best strategy for improving the Federal-State Medicaid partnership is to pursue changes that give States additional program flexibility and yet protect beneficiaries and control Federal costs. This improvement can best occur within the current Federal-State partnership. The Medicaid program can and does provide flexibility for States, but the program's structure also ensures an important degree of continuity across States. This continuity is particularly important in program eligibility certain low-income individuals—such as senior citizens, individuals with disabilities, and children—are Medicaid eligible in every State. Under the current Federal-State relationship, States also draw on Federal expertise and assistance to achieve program goals.

The President's proposal seeks $54 billion in Medicaid program savings over seven years. We want to work with this Committee and the Governors to determine how we can best achieve these savings. We are interested in significant changes. For example, we want to give States more flexibility to pursue certain widely used managed care models by replacing current program waiver requirements with new statutory authority that would make these types of Medicaid managed care a program option that States could elect without extensive Federal review.

We are also interested in building upon our work with the National Governors' Association (NGA). For example, we worked with the NGA to encourage States to expand their home and community-based services programs. We believe that State flexibility in these programs could be further enhanced. HCFA supports the NGA recommendations to repeal requirements for payment rates to obstetricians/pediatricians and to replace the HMO enrollment provisions called the "75/25 rule" (which requires HMOs to maintain at least 25 percent private enrollment) with more outcome-based quality assurance methods. We support provisions that would allow managed care entities to better serve rural areas. We are also evaluating new strategies for guaranteeing access to high-quality services that are more refined than the current Boren Amendment.

We recognize that the growth in Medicaid should be contained. However, we do not want to do this in a way that risks Medicaid enrollees losing coverage. Instead, the President has proposed per capita limits on Federal Medicaid spending, which limit the growth in Federal Medicaid costs but will not force States to restrict Medicaid eligibility. Under per capita spending limits, Medicaid enrollment can continue to expand and contract with changing economic conditions and individual needs. With enhanced flexibility, States will be able to manage within these limits, while Medicaid beneficiaries—including senior citizens, disabled people and children—will retain their health care coverage.

Comparison to Other Proposals

We believe the reductions required in the conference agreement on the budget resolution would damage this critical safety-net program and harm the States, beneficiaries and providers.

The magnitude of the spending cut—$182 billion over seven years—is too big to be absorbed through efficiencies alone. Simply limiting overall Federal matching payments will not make health-related costs disappear. Neither wholesale use of managed care nor any other programmatic change will provide sufficient savings to maintain current coverage levels.

In addition, enrollment growth alone would absorb most of the lower growth rates permitted under the conference agreement. As Chart 5 demonstrates, The Congressional Budget Office's (CBO) projections of Medicaid enrollment growth edge very close to the proposed spending limits in the budget resolution. As you know, medical inflation affects public health care spending as well as private spending. Inflation, added to CBO's anticipated enrollment growth, will drive projected program costs well beyond the spending limits envisioned under the budget resolution. Given the many fiscal, legal and political pressures at work on States, it will be virtually impossible for States to maintain coverage of essential medical services for current Medicaid beneficiaries under the budget resolution.

The President's proposal to reform Medicaid and the budget resolution are fundamentally different. We rely on per capita limits to allow for changes in enrollment, while the budget resolution cuts spending to the point that any unexpected change in enrollment would shift considerable cost to the States or force a reduction in coverage. We fear that States may be forced to reduce growth in coverage. The

States and Congress can realize meaningful savings and additional flexibility without completely dismantling the Medicaid program.

Conclusion

The Medicaid program affords States a considerable amount of flexibility in the design of their individual programs. The Clinton Administration has worked with States to further increase flexibility and permit States' use of innovative means of service delivery and cost containment.

We believe that the President's proposal is the right way to improve the Medicaid program. Flexibility can be achieved within the current program, without taking apart the structure of this program that has served as a critical safety net for populations without many alternatives.

Rather than simply block granting the program which, given the loss of Federal funds, may reduce flexibility for many States, we propose a more targeted approach that builds upon the program's inherent flexibility while also protecting coverage for the nations most vulnerable populations. We want to work with Congress to improve this program in ways that increase State flexibility, control costs and better serve beneficiaries, as the President has proposed.

RESPONSES OF MR. VLADECK TO QUESTIONS SUBMITTED BY SENATOR MOYNIHAN

Question: How would the Administration's per-capita proposal work.

Answer: We have not completed our analysis of the numerous programmatic issues encompassed by a per capita cap. We are developing a per capita limit that will retain the fundamental structure of the Medicaid program. We recognize that the growth in Medicaid expenditures should be contained. However, we do not want to do this in a way that risks Medicaid enrollees losing coverage. The President proposed a per capita limit on Federal Medicaid spending because it will provide an additional incentive for States to control program spending, but not force the States to reduce coverage in difficult times.

Question: What is the percent of Medicaid eligible children who are eligible through AFDC?

Answer: According to FY 1994 figures, the percentage of children who are receiving Medicaid who are also AFDC cash recipients is 56 percent. Senator, let me clarify that the 49 percent figure you are referring to does not include disabled children.

RESPONSES OF MR. VLADECK TO QUESTIONS SUBMITTED BY SENATOR GRAHAM

Question: What cannot be waived under the 1115 program for either legal or administrative policy reasons?

Answer: States can test new approaches to publicly supported health care by obtaining waivers of statutory requirements and limitations from the Secretary of the Department of Health and Human Services. Waivers permit States flexibility from the Federal Medicaid statutory and regulatory requirements that cannot be altered through the Medicaid State plan amendment process. State Medicaid demonstrations present valuable opportunities to both States and Federal policy makers to refine and test policies that improve access to, and quality of care for vulnerable Medicaid populations, and to more effectively manage the costs of providing that care.

Although, section 1115 authority is very broad, certain statutory restrictions exist for State demonstrations. In addition, HHS has made a number of policy decisions that affect statutory provisions we will and will not waive for demonstration programs.

Statutory Provisions

- **FMAP Rates:** The rate at which the Federal government matches States expenditures cannot be waived.
- **Services for Pregnant Women and Children: The obligation to cover certain women and children described in section 1902(1) cannot be waived under section 1115 authority.**
- **Drug Rebate Provisions:** Section 1902 also requires that a State provide medical assistance for covered outpatient drugs in accordance with section 1927, which also contains the drug rebate program provisions. Section 1927 excludes drugs dispensed by HMOs from the requirements of the drug rebate program. Since the drug rebate provisions are imposed on drug manufacturers, and not on the State, this provision cannot be waived through a waiver of section 1902. Only those drug rebate and best price provisions of section 1927 which apply directly to the State may be waived, not those which apply to drug manufacturers.

- **Copayments and Other Cost Sharing:** Section 1916 enables States to impose deductibles, copayments and other cost sharing requirements on Medicaid beneficiaries, but also prohibits States from requiring copayments from categorically-eligible beneficiaries who are enrolled in managed care systems. The Secretary's authority to waive this restriction is limited. These limitations make it impractical to waive section 1916 to enable states to require copayments. Copayments and other cost sharing can be imposed for managed care services, however, in the case of medically needy individually and on individuals who are newly Medicaid-eligible due to the demonstration.
- **Spousal Impoverishment Provisions:** Section 1924 prohibits the Secretary from waiving spousal impoverishment provisions for institutionalized individuals.
- **Work Transition:** Section 1925 prohibits waiving work transition provisions extending Medicaid eligibility for certain individuals who lose their eligibility for Medicaid through their loss of eligibility for Aid to Families with Dependent Children.
- **Qualified Medicare Beneficiaries, Specified Low Income Beneficiaries, and Qualified Working Disabled Individuals:** Section 1905 requires States to provide coverage to these groups of individuals regardless of an 1115 demonstration.
- **Competitive Bidding:** Procurement rules in Part 74 of the Code of Federal Regulations require States and other entities to use competitive bidding "to the extent practical." Because the statutory basis for these rules exists outside of Title XIX, section 1115 cannot be used to waive this requirement.

Policy Positions

- **Reduced Quality of Care:** Programs or policies which inappropriately reduce access, benefits, or otherwise reduce quality of care for current eligibles cannot be approved.
- **Quality Assurance:** States are expected to maintain quality assurance processes (e.g., eligibility quality control, external medical review requirements, etc.).
- **Budget Neutrality:** Demonstrations must be budget neutral. That is, Federal expenditures under the demonstration may not exceed the projected level of Federal payments to the State in the absence of a demonstration.

  Through negotiations with the National Governors Association, HHS has agreed that States may achieve budget neutrality over the life of the project, rather than on a year by year basis.
- **Unnecessary Utilization and Access Safeguards:** Section 1902 requires safeguards against unnecessary utilization of services. The statute also protects access to care by requiring States to make adequate payments to providers. Such safeguards must be maintained.
- **Boren Amendment:** States must meet the Boren amendment's access and payment requirements in fee-for-service settings. Because these provisions do not apply to managed care settings, States do not need a waiver of the Boren amendment for managed care programs.
- **Contract Provisions:** Most existing contract requirements for comprehensive managed care plans in section 1903(m) will continue to apply to managed care demonstrations. HCFA will consider waiving the enrollment composition requirement (the "75/25 rule") and disenrollment on demand if the State plans to substitute a data-oriented, quality improvement system for these statutory provisions.
- **Duration:** The terms "experiment," "pilot," and "demonstration" all suggest that programs authorized under section 1115 should, some point, conclude. Thus, States and health care providers potentially affected by section 1115 demonstration projects should be aware that section 1115 demonstrations are time-limited.

RESPONSES OF MR. VLADECK TO QUESTIONS SUBMITTED BY SENATOR MOSELEY-BRAUN

Question: HCFA opinion of the Chafee managed care bill.

Answer: The Medicaid Managed Care Act of 1995, S.839, would allow States to adopt managed care programs as an optional service in Medicaid through the State plan amendment process. Other proposed changes that would enhance State flexibility include: eliminating the 75/25 enrollment rule; permitting States to lock Medicaid enrollees into a health plan for up to 12 months; and exempting capitated plans that are either accredited by an independent organization or contract with the Medicare program from external review requirements.

In general, we appreciate this bill's focus on increasing State flexibility in the Medicaid program by largely eliminating the need for States to obtain program waivers from HCFA. We also support its general approach to quality assurance in Medicaid managed care—that is, replacing the current proxy for quality, the 75/25 enrollment rule, with meaningful quality requirements.

However, we also have some general concerns. We are currently developing specific comments regarding the bill as introduced, including comments on the quality assurance requirements, the length of time managed care enrollees can be locked into a health plan, and issues related to exemption from external quality reviews.

While we believe that these issues should be addressed as Congress considers this legislation, we generally support the bill's intent to increase State flexibility in Medicaid managed care.

RESPONSES OF MR. VLADECK TO QUESTIONS SUBMITTED BY SENATOR D'AMATO

Question 1: We are on the Senate floor discussing legislation which requires the evaluation of regulations where costs are in excess of the benefits, or where regulations divert scarce resources from the direct provision of care. I have been educated about the potential impact of your agency's Survey, Certification and Enforcement regulations on the provision of care in nursing homes. What is the status of these regulations?

Answer: The regulation was published in the Federal Register on November 10, 1994 and became effective on July 1, 1995. Prior to that date, an intensive training effort conducted by HCFA trained approximately 5,400 individuals, 4,654 of which were State survey and certification personnel. In addition, 95 provider organizations and 56 advocacy groups received training. HCFA instituted an intensive monitoring process which includes, concurrent with implementation, weekly reporting from States regarding the number of surveys conducted, number and type of remedies recommended, and other relevant data.

Question 2: Could you describe the expected rise in the numbers of nursing facilities expected to be subject to fines and/or penalties under the new regulations?

Answer: HCFA has been closely monitoring the implementation of the survey and enforcement process since it took effect on July 1, 1995.

- *Compliance Actions:* Facilities that are not chronic poor performers or that have not placed residents in immediate jeopardy but are found substantially out of compliance with requirements are given up to 90 days to correct the deficiency and to come into compliance. Although survey agencies *propose* remedies for these facilities, many will correct the problems before the penalties are *imposed.* As of September 15, 73 percent of the 2520 facilities surveyed were initially found out of compliance. However, of the 148 facilities rechecked so far, *over 92 percent were able to achieve compliance,* therefore incurring no fines or other remedies. This is testimony to the philosophy behind OBRA 87: the nursing homes will improve care by complying with standards when required to do so by a strong enforcement program.
- *Immediate Jeopardy:* Immediate jeopardy is declared only in the most extreme cases—when immediate corrective action is necessary because the provider's performance has caused, or is likely to cause, serious injury, harm, or death to a resident receiving care in a facility. Instituting immediate sanctions against such a facility is essential to protect resident health and safety.

  Chronic Poor Performers: Another category of providers which warrant the imposition of a remedy without a prior opportunity to correct are chronic poor performers—those nursing homes which year in and year out have had major deficiencies and provide poor care. Only fines and other serious sanctions are likely to improve care in these facilities.

  Since July 1, 83 facilities or 3 percent have fallen into these categories.
- *Substandard Care:* OBRA '87 provides for a new category of facilities that provide substandard quality of care. Currently about *18 percent* of facilities fall into this category. Substandard quality of care is defined as a deficiency in quality of care, quality of life, or resident behavior and facility practice that is deemed to have caused actual harm to at least a group of residents or has the potential to cause actual harm on a widespread basis in the facility. HCFA's review of state agencies' determinations indicates that they are accurately interpreting the regulations.

It is important that we not confuse the number of facilities found to be out of compliance with those facilities that will actually experience a Civil Money Penalty or other enforcement remedy. A rise in the number of facilities found out of substantial compliance with the participation requirements is neither unexpected nor inappropriate. The vast majority of facilities will be afforded an ample opportunity to correct their deficiencies before any remedies are imposed. The array of remedies available under the new regulations is intended to promote prompt and sustained compliance. We are confident that the great majority of facilities, who recognize their responsibility to provide high quality care and promote an enhanced quality of life for their residents, will avoid the imposition of remedies.

Question 3: What analytical and statistical studies have been conducted to validate that only poor performing nursing facilities will be captured under the new enforcement regulations?

Answer: Because this new system has only been in place since July 1, it is difficult to, with any degree of accuracy, predict the percentage of facilities which will be subject to enforcement action. We have requested relevant information from States for analysis and will give the results of that analysis to the groups of advisors appointed by HCFA to help us fine tune our policies, as necessary.

In the meantime, noncompliant facilities with a good performance record will be given an opportunity to correct deficiencies before penalties are imposed and that facilities with a history of poor quality care to nursing home residents will be subject to immediate enforcement action.

Question 4: What is the exact definition of "harm" under the new regulations, and what accepted standards will HCFA use to substantiate the potential for "harm" to occur?

Answer: Under the new regulations "actual harm" is defined as: Noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.

Nursing home requirements under 42 CFR §483, Subpart B, set standards for acceptable health care practice, quality of life, and safety. Any time a nursing home fails to meet a requirement under these regulations, there exists at least the potential for a nursing home resident to experience harm. For example, if a facility has an ineffective infection control program the health of many or all residents of the facility is jeopardized. Similarly, if a facility places a resident in physical restraints without any consideration of the medical necessity of the restraint, the resident faces physical and emotional harm. After determining that a deficiency—a failure to meet a regulatory requirement—exists, the State survey agency must determine whether or not the there was an actual negative outcome that had an impact on a resident or on a group of residents, or whether there existed only the potential for a negative outcome. The survey team distinguishes between existing and potential harm by assessing the deficiency's effect on the resident. If a negative outcome exists and is documented, the survey team concludes that some level of harm has occurred.

Question 5: You have stated that you will be reviewing the implementation of the regulation during the first 90 days. What kinds of sanctions will facilities be subject to during this period? What steps are you prepared to take if you find during this review period that significantly more nursing homes than you had expected are being classified as out-of-compliance or substandard?

Answer: The majority of the facilities are being given an opportunity to correct deficiencies before most sanctions are imposed. The recommended sanctions for these facilities during the first 90 days could include remedies such as directed in-service training (where the State or HCFA direct the facility to get training in areas where noncompliance was identified), State monitoring (where the State sends a monitor to the facility to observe corrections), and directed plan of correction (where the State or HCFA directs the facility to make specific corrections), civil monetary penalties and termination. However, during this monitoring period, facilities which are found to cause an "immediate jeopardy" or facilities which have a history of noncompliance are immediately subject to the whole array of remedies, including civil money penalties.

Further, facilities found out of compliance during this monitoring period that do not pose an immediate jeopardy or are not poor performers will receive recommendations for sanctions at the time of the survey. Facilities continuing to be out of compliance will have the recommended sanctions (except for CMPs) imposed effective the time of the resurvey. With respect to CMPs, facilities surveyed during the monitoring period and continuing to be out of compliance at the end of the monitoring period will have the recommended CMPs imposed retroactive to the date of the initial survey.

Once we have analyzed the data we are currently receiving from the States, we will evaluate the data to see what changes are needed. If the long-term care delivery infrastructure is inadvertently adversely impacted during the implementation phase, we can, if necessary, seek emergency legislation, revise regulation or modify certain administrative procedures to help remedy these identified problems.

Question 6: What recourse does a nursing home administrator have under the new regulations if they have reason to believe a surveyor has not adequately or fairly measured what was going on in a facility? What remedies can they seek?

Answer: The nursing home enforcement regulation includes an informal dispute resolution process. Providers that disagree with survey findings are free to dispute those findings through the States' informal dispute resolution process. The initial letter to the facility informs them of their rights and describes the procedures for requesting dispute resolution. The regulation also permits facilities to subsequently appeal the noncompliance which led to a remedy through a formal appeal mechanism. Providers have no direct recourse against a surveyor or the State. However, if a provider prevails during informal dispute resolution or a formal appeal, any remedies which had been put in place would be rescinded.

Question 7: I can assure you that I and other members of this committee will be watching carefully with respect to the new rule's impact, and to your agency's response to those impacts. What steps do you intend to take to keep the committee apprised of your findings as this new rule is implemented?

Answer: As indicated, we have instituted an intensive monitoring of implementation of the early enforcement regulations and survey process. We will continue to be available to conduct informational briefings to committee staff (or members), as necessary, during this early phase of implementation to apprise the Congress of our findings.

PREPARED STATEMENT OF GAIL R. WILENSKY, PH.D.

Mr. Chairman and Members of the Committee. Thank you for inviting me to appear before the Committee to testify about the recent growth of the Medicaid program, the program's administrative structure, the need for greater flexibility, and the use of the waiver process. I am currently the John M. Olin Senior Fellow at Project HOPE, an international health education foundation, and the chair of the Physician Payment Review Commission. I am here today, however, not to represent either of these organizations, but to speak from my experiences as Health Care Financing Administration Administrator during the Bush Administration.

The Need For Reform

Medicaid has played a vital role in helping states finance the health care needs of our nation's most vulnerable citizens. Medicaid is a state-administered program, funded jointly by the Federal and state governments, that currently funds services for about 37 million low income people. States receive Federal matching funds to finance Medicaid based on a formula that varies with the state's per capita income. The Federal share varies from 50% to 83% of the total funding. The Medicaid program allows states substantial flexibility, in terms of the services that can be provided, the populations that can be covered, and the way that the program is administered.

Although it is frequently maligned for providing expensive, fragmented care to people in high cost and inappropriate settings, by most measurements Medicaid has met its basic objective of providing health care to selected categories of low income populations. We should applaud the successes that Medicaid has achieved, but we should also acknowledge the need for changes—changes that will reduce the growth in spending and lessen the burdens that have been imposed on the states responsible for administering the program.

A variety of reasons have been given to explain the growth in Medicaid spending, which in most states has made Medicaid the fastest growing component of the state's budget and the second largest category of state expenditures after education. These reasons include increasing caseloads, additional requirements that have been placed on the states by the Federal government, and the discovery of what were effectively Federal-only dollars during the early 1990s.

At least part of the increased spending can be attributed to the increased use of mandates during the last decade. These mandates included new populations that had to be covered—such as all pregnant women and children up to age 6 with family income up to 133% of the poverty line, all children born after 1983 to families in poverty, and increased numbers of elderly through the Qualified Medicare Beneficiary program—and new services that had to be provided—such as all needed services discovered during a screening visit under the EPSDT program, whether or not otherwise covered by the state's Medicaid program. It also included new requirements about how and by whom services were to be provided, particularly for people in nursing homes.

In addition to the mandates, new options were made available regarding the populations that could be covered under Medicaid, particularly women and children. This, along with the flexibility to bring in previously uncovered populations provided through the 1115 waiver process, allowed states to shift what previously had been state-only dollars to Medicaid, which made them Federal/state dollars.

A third factor explaining the rapid growth of Medicaid spending was the development by several states of creative financing strategies to fund their share of the match. This was a critical moment in the program's history, because it began to undermine the basic premise of the financial structure of Medicaid—that funding be shared through a Federal match of State monies. Matching grants presume that those responsible for spending decisions have a reasonable stake in the program's costs. In fact, the only real cost containment mechanism that exists in the Medicaid program is the State's share of the costs. By its structure, Medicaid is an open ended matching program, with no limit on Federal payment.

The discovery of strategies by states to enhance their Federal matching share, at little or no cost to themselves, along with the other pressures to increase spending, had the not very surprising result of producing explosive growth rates during the early 1990's. Medicaid, which had been growing at rates that varied between 8% and 12% earlier in the 1980's, grew at rates of almost 19%, 32% and 28% for the years 1989-90, 1990-91 and 1991-92, respectively. These rates of growth have since slowed to rates closer to those of the 1980's, with growth in the Medicaid program projected at rates between 9% and 11% for the rest of the decade. Although obviously less than the rates of the early 1990's, these growth rates are far in excess of most of the rest of the Federal budget, which, excluding health and interest on the debt, is projected to grow at rates of 3.8% per year for the rest of the decade.

Lessons Learned From Donations and Provider Taxes

States showed remarkable creativity in the strategies they devised to enhance their share of Federal dollars. West Virginia started the process in 1986, but at least 30 states were involved by July of 1991. The specific strategies varied substantially, but basically each worked in the following way. A state borrowed money from providers through donation or tax programs. The money was used as the state's share of Medicaid and was matched at least dollar for dollar by Federal funds. The state would then increase Medicaid payments to reimburse providers for the donations or taxes they had paid. In many states, providers were guaranteed to get back at least as much as they donated or paid in provider-specific taxes through hold-harmless mechanisms. The funds were most frequently distributed via "disproportionate share" payment strategies (payments to hospitals providing a disproportionate share of services to low income populations) that allowed states to reimburse institutions in excess of the amounts spent providing care to low income people.

Legislation was passed in the fall of 1991 that limited the amount of revenue that could be used for purposes of Federal match from taxes that were limited to medical providers, eliminated the use of donation strategies, and limited the amount of funds that could be received as disproportionate share payments. States had a minimum of one year to comply with the new requirements (some states whose legislatures only met on a biannual basis had two years to comply). As frequently happens, some states had been much more aggressive than others in increasing their effective Federal match rate. Those states were allowed to maintain their high rates of provider taxes for a period of time and were allowed to keep very large levels of disproportionate share spending while other states were limited in what they could introduce or claim.

Legislation was also passed in 1993 which limited disproportionate spending allocations to the amounts institutions had spent furnishing hospital care to Medicaid-eligible and uninsured patients (less the amount they had received directly from Medicaid for providing services to Medicaid eligible individuals). This meant that the total money received from Medicaid couldn't exceed the cost of providing hospital services to low income populations, something which had happened with some frequency before the legislation was passed.

The experience with provider taxes, donations and disproportionate share spending was a rude awakening regarding the fungibility of money. In general, the 1991 legislation, combined with the 1993 legislation, shut down the abusive provider tax and donation funding arrangements which the states had adopted. Tennessee may be an exception. Tennessee used a new services tax which included hospital service and combined it with the use of a sales tax that exempted certain activities, such as those included in the new services tax. The state borrowed revenue from the new services tax and used it, in part, for its Federal match. There is an ongoing court case as to whether this practice violated the 1991 law, but, since there wasn't a clear baseline to start from, it will be very difficult to prove that adding a hospital tax to a pre-existing tax violated the law. It is also no longer currently relevant, as Tennessee has capitated its entire program into TennCare. To the extent that Tennessee had expanded its baseline to include questionable or even inappropriate expenditures, the state will carry more money forward into the future than it would have been able to do otherwise, with effectively no chance for the Federal government to ever recoup that money.

The bigger concern today has to do with intergovernmental transfers. Intergovernmental transfers was an area of concern in 1991, but those of us working on the issue at HCFA were unable to devise a rule which would distinguish between an intergovernmental transfer that represented a legitimate transfer between levels of government and the movement of funds which results in only new Federal money coming into the program. It is particularly problematic when the county or state is paying itself because it owns the hospital and is putting up its share of the match with an intergovernmental transfer. The absence of an ability to distinguish appropriate uses and abusive uses of intergovernmental transfers is a good reminder that money is fungible and that reliance on the use of state matching as a cost containment strategy is a genie that can never be put back into the bottle.

The Waiver Process

Although the amount of legislation and regulation associated with the Medicaid program is substantial, the flexibility provided by the waiver process allows the Federal government to waive any individual component of Medicaid as long as the resulting change is in keeping with the spirit of Title XIX. Thus provisions of statewideness, duration and scope, freedom of choice, the Boren Amendment, etc., have all been waived as part of requests by states for more flexibility in designing their Medicaid programs.

The flexibility provided by the waiver process has allowed states to experiment with changes that have enabled states to improve the efficiency with which they provide care and have given states the ability to more effectively provide care for various difficult subgroups in the population, such as high risk teens, pregnant women, frail elderly and so forth. The 1115 waiver, which removes certain restrictions on the use of managed care delivery systems and also allows coverage of individuals not normally covered by Medicaid, has been especially popular. Since 1993, HCFA has granted 10 statewide 1115 demonstration waivers. Thirteen other states have 1115 waivers under consideration or discussion.

While much good has been associated with the waivers, there have also been areas of concern. Some of the concern has to do with the administrative complexity, burden and costs associated with the application process and subsequent monitoring by HCFA. Despite the efforts that I undertook to streamline the waiver process while I was at HCFA and the efforts that the current Administration has undertaken since then, states continue to feel that the reporting and filing requirements associated with the waiver process are costly and burdensome. State representatives are only too eager to show the piles of paper required for waivers or as part of the state plan amendment process (the fundamental statement of how a state's program will function or change during a future period of time). States continue to be frustrated at the time and expense required to include changes that have been tried in other states or are a regular feature of the private market.

States and the Secretary of Health and Human Services are forced to use HCFA's research and demonstration authority to continue implementing successful changes in state programs, since that is the only statutory authority available for their continued implementation. The most notable example is Arizona's AHCCS program. This program was introduced in 1983 and provides the state with authority to run its entire Medicaid program under a waiver. The State has used a combination of managed care programs in urban areas combined with primary case management in rural programs to produce a highly successful Medicaid program that has provided its recipients with greater access to physicians and other primary care personnel than exists under most Medicaid programs while experiencing lower rates of spending growth than has occurred nationally. Despite this fact, twelve years later Arizona must continue to operate under a research and development waiver, with the sham that suggests for process, because it does not conform to many of the requirements of Medicaid.

A second area of concern has to do with the determination of budget neutrality that appears to have been used in some of the waiver requests, when, in fact, common sense would suggest that provisions were included that make them "costers" to the Federal government. In particular, there are questions as to what the Federal government would have spent in the absence of the waiver as well as questions about the states' use of the Federal share of savings from managed care plans to fund coverage of people not otherwise included in Medicaid.

Let me give a few examples. When Hawaii requested a waiver during the early part of the Clinton Administration, it was allowed to calculate Federal contributions which would have occurred if Hawaii had taken advantage of all of the options, in terms of populations and services covered, available to it, even though Hawaii had not, in fact, included many of these options in their program. In my opinion, this use of 'hypothetical spending' in no way meets a common sense definition of the term "budget neutral," that is, equal to the amount which would have been spent in the absence of the waiver.

A second example involves the TennCare program. This is a program that has raised a lot of controversy because of the pressure that the Blues placed on providers to participate in the program. Much less attention has been given to the fact that Tennessee has claimed it was able to cover 364,000 previously uninsured individuals because of the savings associated with managed care, and has therefore been able to lay claim to all the additional Federal dollars generated from this in a transaction that has been designated as budget neutral. The Committee knows that I am a supporter of managed or coordinated care for vulnerable populations, but these claims of savings seem beyond belief, even to an ardent supporter. The General Accounting Office has raised similar questions concerning increased Federal spending for the demonstrations in Florida, Hawaii, and Oregon.

I am not necessarily against the individual expansions or the programs that have been produced by the creative use of "budget neutrality," but I am very concerned with what this does to the budgeting process and the ability of government to gain control over its own spending levels. Just as I didn't necessarily object to some of the programs that states funded with their provider and donation money, I believed then, as I believe now, that we must run government at levels that the public is willing to fund and not at levels that other well-meaning people believe is appropriate even in the face of public unwillingness to provide such funding levels.

The Choices for a Reformed Program

Tinkering with the existing program will not solve the fundamental problems of Medicaid—an unsustainable growth in spending and burdensome, costly requirements on the states. The major alternatives facing the Congress are the use of a capped payment per person covered under Medicaid eligibility rules or the use of a block grant. The most significant difference between these strategies is that the capped payment per person option maintains an entitlement between the Federal government and the individual, whereas the block grant does not. This is an important philosophical issue that should be debated on its own merits, but there is also concern that any strategy other than a block grant strategy exposes the Federal government to uncertainty with regard to future spending and the potential to be "gamed" by the states in terms of claims for Federal funding.

Both of these strategies, but particularly the block grant, will relieve the states from much of the regulatory burden associated with the current system. The prescriptive nature of existing law and regulation would be replaced with a limited monitoring function for the Federal government. Rather than focussing on the specifics of process and inputs, as is currently the case, the Federal government's role would be one of monitoring and auditing. HCFA's role would be to audit the states to assure that Federal monies were being spent on health care and on the low income population, however they were defined in statute, and that the states were meeting whatever "maintenance of effort" requirements were put into law.

In addition, consideration is being given to putting a limited number of performance or outcome measures into law. The irony is that, if this occurs, Medicaid could require information from the states on access to care, use, or health outcomes for their low income populations which it does not now require, despite all the mountains of paperwork which HCFA demands from the states. In fact, because of a lack of uniform reporting requirements on use, claims, and expenditures, it is very difficult to assess the effects of the Medicaid program from HCFA data.

The result is that if block grants (or capped payments per capita) were to be adopted, states would be relieved of the burdensome reporting and filing requirements associated with the current regime, but would be expected to provide a minimum set of information on outcomes and performance. It seems to me that this is a trade worth making. Whether the increased flexibility will be worth the lower rates of growth being suggested to the governors will be an important determinant of the successful adoption of these changes.

A significant philosophical issue underlies the choice between the current administrative structure with its division of responsibility between the Federal government and the states and that implied by block grants. That issue is whether the states, given some additional financial resources and with the Federal government assuming a reasonable monitoring role, can be relied on to take care of their most vulnerable populations, or whether only the Federal government can be presumed to care about these vulnerable populations and that without its active involvement, those populations will not receive adequate or appropriate care. This is an issue that's worth debating.

COMMUNICATIONS

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

The American Medical Association (AMA) is pleased to have this opportunity to express our views regarding Medicaid during this critical time when Congress and the Administration are considering a fundamental restructuring of the program.

BACKGROUND

Medicaid is a program through which the federal government grants funds to participating states to furnish medical assistance on behalf of the eligible needy (Title XIX of the federal Social Security Act, commonly known as the "Medicaid Act"). The objective behind the Medicaid Act is to improve access to quality medical care for states' most vulnerable populations.

In an effort to achieve its goal of achieving a balanced budget by the year 2002, Congress has passed a resolution to reduce Medicaid spending over a seven year period by $182 billion, relative to Congressional Budget Office estimates of future Medicaid expenditure increases, by placing a cap on federal Medicaid expenditures. Under the proposed cap, federal expenditures would continue to grow on an annual basis, but eventually would be limited to 4% annual increases, rather than the 10% annual increases projected under the current system.

For years, state leaders have called for significantly greater flexibility in designing and administering Medicaid programs that meet their needs, goals and budgetary constraints. Traditionally, they have viewed federal requirements relating to Medicaid as bureaucratic and inefficient, particularly with regard to mandates for expanded coverage that increase costs and provisions that require them to procure formal waivers in order to implement mandatory managed care, add additional uninsureds to the Medicaid program, prioritize covered benefits, create alternative long term care systems or implement other measures designed to control costs. The call for flexibility has been driven primarily by the fact that Medicaid programs have consumed an increasing portion of state budgets. Many state leaders are willing to accept fewer federal Medicaid funds in exchange for significantly increased flexibility and relief from federal mandates and regulation.

The AMA supports efforts to create a streamlined Medicaid program that will promote state innovation and efficient use of funds, while maintaining the program's role as a safety net for the nation's poorest and most vulnerable populations. A major challenge in restructuring the Medicaid program is to appropriately balance states' interests in securing increased flexibility in light of fewer federal funds for Medicaid against the very real needs of the people that the Medicaid program is intended to serve, most of whom have no other means of access to health care coverage.

As exemplified by some of the programs for which broad waivers have been granted, states unfortunately place budgetary concerns over those of patient access and choice, reasonable provider reimbursement, and solvency of participating managed care entities. The result is that beneficiaries' access to quality medical care suffers. The AMA believes that state flexibility must be tempered by the need for accountability standards designed to ensure that state programs fulfill Medicaid's objective of improving access to quality medical care and comply with fundamental protections embodied in the Medicaid Act. Such standards are also critical to assuring that state Medicaid programs will have sufficient provider participation to meet the beneficiaries' needs, without resorting to coercive approaches to securing that participation. Moreover, for states that choose to move their Medicaid populations into managed care systems in hopes of achieving savings, safeguards are necessary to ensure that Medicaid beneficiaries receive high quality, cost effective care and are treated fairly.

In addition, it is essential that federal reforms are enacted that facilitate the purchase of private health insurance for Americans who do not qualify for Medicaid. The AMA has long supported federal and state efforts to promote access to health coverage, including insurance reforms such as portability, community rating, and elimination of pre-existing condition limitations; the creation of voluntary private sector health insurance purchasing cooperatives; and buy-in programs that allow low-income individuals to participate in state Medicaid programs. These reforms will become even more critical in a time of a more limited Medicaid program.

The AMA supports the following principles to apply under any restructuring of Medicaid, including a block grant program, a continuation of the current program with expedited state Medicaid waivers, or a program that would combine a block grant approach for certain portions of Medicaid with an expedited waiver process.

INCOME-BASED ELIGIBILITY WITH NATIONAL FLOOR

Because of limited federal and state resources for Medicaid, states will face difficult choices regarding who will be eligible for Medicaid coverage. An eligibility floor is essential to ensure that states will not cut coverage for the poorest Americans, which would add to the growing numbers of uninsureds and exacerbate cost-shifting and uncompensated care. At a minimum, states must provide Medicaid coverage to those whose incomes fall below a federal eligibility requirement, set at, or at some percentage of, the federal poverty level. While the existing categorical requirements structure should be eliminated, states should also be required to maintain current efforts in covering children to age 16, pregnant women and dual Medicaid-Medicare eligibles. These federally required eligibles are the "core eligibles."

MINIMUM ADEQUATE BENEFITS

Basic standards of uniform minimum adequate benefits need to be established for Medicaid recipients. Without such standards, states may use their discretion under a restructured Medicaid program to drastically cut Medicaid benefits, resulting in inadequate coverage for beneficiaries and increased uncompensated care costs for our nation. Minimum adequate benefits also will provide some equity and comparability of Medicaid benefits across states. States should have the flexibility to provide additional benefits to beneficiaries as they choose, using their own resources.

ACCESS STANDARDS

Under any restructuring of the Medicaid program, the desire of states to have the freedom to tailor their Medicaid programs to best meet their needs must be balanced against the necessity for more active federal oversight if a state's management of its Medicaid program results in significantly diminished access and/or quality of care provided to eligibles. To allow for this, Congress should require the development of certain "access standards" by which to measure Medicaid eligibles' access to providers and covered health care services. These standards must include guidelines for adequate provider reimbursement levels, which have a demonstrated link to beneficiaries' access to medical care.

HCFA should also monitor states' progress in meeting these access standards. Upon finding that a state has failed to meet such standards, an oversight process should be established whereby a state will be required to engage in certain activities designed to rectify problem areas. This oversight authority should continue until the state is in conformance with the access standards. Interested parties, including the AMA and state medical societies, should have input at the federal and state level into the development and implementation of access standards.

PROMOTING PATIENT EMPOWERMENT AND MARKET COMPETITION

Medicaid beneficiaries should be empowered to utilize Medicaid funds in the most rationale, efficient manner possible. Rather than a single health delivery system dictated by the state or the federal government, which generates inefficiencies and stifles a competitive market, Medicaid beneficiaries should be provided with as many choices of health delivery systems as possible, including managed care, traditional indemnity, and benefit payment schedule where available, within a defined contribution framework. This will achieve the twin goals of predictable Medicaid expenditures and price and quality competition in the Medicaid market.

1. Medical Savings Accounts and Vouchers

Medical Savings Accounts (MSAs) provide strong incentives for patients to become cost conscious and informed about their care options. Further, MSAs allow patients—not managed care plans or utilization reviewers—to assert control over their health care decisions, options for care and choice of physicians. Through the use of MSAs and vouchers, states may integrate Medicaid recipients into the commercial insurance market which will improve access and quality in the long term.

Congress should enact federal legislation establishing medical savings accounts (MSAs), which would allow states to extend MSAs to their Medicaid eligibles. States could then fund MSAs for Medicaid eligibles directly or issue publicly-financed vouchers for an actuarially determined amount of insurance to allow Medicaid eligibles to choose among private health insurance plans that provide required benefits. Issuance of a voucher may be coupled with a medical savings account.

States that employ a voucher and/or MSA approach for their Medicaid population should ensure that Medicaid recipients are provided with a choice among types of health delivery systems. States should be permitted to allow their Medicaid eligibles to carry over accumulated savings in their MSAs on a tax free basis. States should also be permitted to allow Medicaid eligibles to use funds accumulated in MSAs above a state-specified level for certain designated usages, i.e., education tuition, long term care expenses or purchase of a home.

In order to ensure that Medicaid recipients obtain necessary care while purchasing health care services in a cost-effective manner, states that implement a voucher and/or MSA approach should establish programs to educate Medicaid eligibles regarding medical savings accounts and the efficient use of health care services.

2. *Physician-Sponsored Coordinated Care Organizations*

Innovative states have recognized the benefits of creating incentives for providers to treat Medicaid patients by enacting laws that facilitate physician sponsored entities' ability to "manage" the care of Medicaid beneficiaries. Allowing PCCOs to contract to cover Medicaid beneficiaries creates a competitive atmosphere for Medicaid business and promotes high quality for Medicaid beneficiaries by placing medical decisionmaking and quality assurance activities in the hands of those who are responsible for providing the care. Physician sponsored entities that contract directly with states to cover Medicaid recipients also are able to reduce the cost of the insurer "middleman," who diverts a layer of the Medicaid dollar from patient care.

Eliminating barriers to PCCOs' ability to contract for Medicaid business will contribute to the evolution of these entities and will result in enhancing competition in the commercial health care market, which is currently dominated by insurance companies. Federal and state laws that create barriers to the provision of health services by PCCOs should be modified to facilitate direct contracting. The legal areas that need adjustment include: antitrust, self referral, fraud and abuse, pension plans, state certificate of need laws, regulation of tax exempt entities, and insurance regulation.

3. *Health Plan Standards*

Regardless of the method for financing or delivering Medicaid health care services, the paramount concern must be the quality of patient care. In an increasingly competitive market, and with fewer Medicaid dollars, health plans face incentives to ration patient care, reduce choices of physicians, deny treatment and base medication and other clinical choices on cost rather than quality considerations. Plans often apply similar pressures on providers as a condition of participating in the plans.

Patients must be protected from practices that are unfair or impair the quality of care that they receive. Under the current waiver system, states are increasingly moving their Medicaid populations into managed care systems, often on a mandatory basis. In some states, this has resulted in poor quality, unscrupulous enrollment practices and a massive displacement of traditional Medicaid providers resulting in the disruption of the continuity of patient care.

States also should create mechanisms for traditional Medicaid providers, who have been serving this population for decades, to continue to participate in Medicaid managed care, where it is implemented. These providers include minority and international medical graduate physicians, community health centers and public hospitals. We must avoid the situation where a major urban medical center, such as the Los Angeles County-University of Southern California Medical Center, faces closure because health plans ignore such important community resources.

Moreover, accountability standards and state oversight requirements must be established for health plans that contract to cover Medicaid beneficiaries. These standards must address: coverage, marketing, and enrollment, fairness, physician involvement, quality management/utilization review, administrative simplification, and incentive plans.

QUALITY IMPROVEMENT SYSTEMS AND QUALITY PERFORMANCE MEASURES

A revolution is occurring in medicine which promises to substantially reduce costs while maintaining and enhancing quality. However, this revolution will not succeed unless a coordinated effort is made to develop the tools necessary for the revolution to take place. Medical societies, many other private sector organizations, accrediting agencies, and government agencies are working at creating tools necessary for the revolution. However, these efforts are fragmented and duplicative, and the tools needed are being developed at far too slow a pace. The tools being developed to achieve the revolution include:

- Practice guidelines that synthesize medical knowledge about a topic to assist physicians in the management of patients. Outcomes research and technology assessment are important sources of information for the development of practice guidelines.
- Utilization review or coverage decisionmaking systems that review the medical decisions made or recommended by physicians. These are based on practice guidelines and algorithms.
- A standardized electronic patient record that allows the measurement and aggregation of outcomes information.
- Outcomes research to develop a base of information about what clinical practices are truly effective in helping patients.
- Technology assessment to determine what medical technologies are effective in helping patients and the conditions under which those technologies are effective. Outcomes research is essential to technology assessment.
- The development of algorithms or protocols for physicians to follow in the management of patients with particular conditions. These are based on the knowledge synthesized in practice parameters.
- Profiling systems to evaluate the quality and effectiveness with which a physician manages patients. Ideally, these are based on practice parameters and algorithms.
- Outcomes reports by providers and health plans that inform the public about their performance.

Much more could be accomplished if all of these activities were coordinated and focused. The AMA endorses the establishment of a Partnership for Health Care Value. The Partnership should be governed by representatives from medical societies, hospital associations, insurers and national managed care companies, accrediting agencies, employers, consumer groups, and the federal government. The Partnership should marshal private sector resources devoted to the development and application of medical standards. The Partnership should also work in cooperation with federal agencies, HCFA, the National Institute of Health, and others. Federal agencies should have input in setting priorities for the Partnership and in reviewing its results.

The work of the Partnership would include:

- Developing standards for outcomes measurement and reporting, including the content and format of electronic patient records, and guiding and coordinating efforts to gather outcomes data.
- Developing standards for and coordinating effectiveness research and technology assessment.
- Coordinating technology assessment and establishing standards for technology dissemination, dispersion and use.
- Establishing priorities for guideline development through analysis of variations in practice or important procedures.
- Creating guidelines for, coordinating the development of, and disseminating practice parameters.
- Developing tools and educational programs to change practice patterns.

States should use the standards and other work product developed by the Partnership in their quality improvement systems, with the goal being to assure that Medicaid beneficiaries receive medically necessary and appropriate care with the optimal use of health care resources. Each state must oversee the quality improvement efforts of health plans and other providers that contract to cover Medicaid beneficiaries by collecting encounter data. States should then provide HCFA with aggregate encounter data for use in monitoring quality and access for the Medicaid population and relevant sub-populations. Upon finding that a state has failed to meet quality improvement standards, an oversight process should be established whereby a state would be required to engage in certain activities designed to rectify problem areas. This oversight authority should continue until the state is in conformance with the quality improvement standards.

Health plans serving Medicaid beneficiaries should be required to have internal, physician-directed quality improvement systems, subject to state oversight, which are comparable to those used in the private sector. A mechanism for physician input into the plan's medical policies, utilization review criteria and procedures, quality and credentialing criteria, and medical management procedures should be established by each health plan contracting to cover Medicaid beneficiaries. Quality performance and outcomes measures developed by the Partnership may serve as the basis for financial incentives designed to reward the provision of appropriate medical care.

MECHANISM FOR ADJUSTING FEDERAL EXPENDITURES

Absolute caps on federal expenditures for each state that are based on present spending levels fail to take into account current discrepancies among state Medicaid programs' benefit packages and eligibility standards. Rigid caps also ignore future variations in state economic situations and/or growth in core eligible populations. Failure to account for these interstate variations will lock in and perpetuate current inequities and could leave states without adequate funding to provide coverage to Medicaid core eligibles. Furthermore, caps based on present expenditure levels do not reward, and may even penalize, those states that have implemented Medicaid programs that are delivering quality care in a cost-effective and efficient manner.

A mechanism must be established for adjusting federal expenditures in a state when its number of core eligibles changes, as in times when a state is experiencing a recession or significant demographic shifts. This mechanism should also work to decrease federal funding in states that have a decrease in Medicaid expenditures due to these factors. The AMA would also support mechanisms for increasing federal funding for programs with demonstrated ability to meet quality, access and other accountability standards.

Congress should also study the feasibility of alternate mechanisms for spreading risk for unanticipated increases in Medicaid expenditures for core eligibles that would not require additional federal expenditures, including: reinsurance, an interstate and/or intrastate risk pool and a "savings set-aside" requirement.

LONG TERM CARE

Medicaid is the largest payor of long term care costs in the United States. The long term care component of Medicaid consumes 35% of Medicaid spending, and Medicaid pays for 52% of all nursing home expenditures.[1] Currently, few Americans purchase long term care insurance. Instead, even middle-income Americans who require long term care often access Medicaid to cover their costs by sheltering and disposing of their assets and thus "spending down" for Medicaid coverage. A result of this phenomenon is that the taxpayer pays for long term care of individuals who could afford to purchase the care and/or long term care insurance, while ensuring inheritances for middle-class Americans. This drains Medicaid money from intended beneficiaries—America's poor.

The federal and state governments must establish incentives and mechanisms for individuals to plan for their long term care costs. Stronger federal requirements should be implemented to limit individuals' ability to divest or transfer assets in order to qualify for Medicaid long term care coverage. States should phase-in rules to allow individuals an opportunity to purchase long term care insurance and establish a spend down "offset" for individuals who purchase such insurance.

Currently, waivers are required for states to shift long term care from costly institutional care to community-based and home-based approaches. The GAO recently reported that states that have implemented case management programs for long term care have achieved savings in this area that allow funding of more individuals' long term care needs. Congress should eliminate waiver requirements for states to implement long term care projects that utilize case management approaches, emphasize community-based or home-based care or use Medicaid funds to facilitate the purchase of long term care insurance.

Further, potential alternative methods of financing long-term care must be studied including, but not limited to, the use of the following devices: MSAs; long term care insurance, including the possibility of Medicaid-funded stop loss coverage and tax incentives for employers to provide and individuals to purchase such insurance; and tax incentives for family caregiving.

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[1] *Medicaid: Spending Pressures Drive States Toward Program Reinvention.* United States General Accounting Office, Report to the Chairman, Committee on the Budget, House of Representatives, April 1995.

GUIDELINES FOR PROVIDER REIMBURSEMENT

States have historically set Medicaid provider reimbursement levels considerably below private sector and Medicare levels. In 1993, Medicaid reimbursed at approximately 47 percent of private sector fees and 73 percent of Medicare levels.[2] As long as Medicaid reimbursement levels remain considerably below those of other payors, there is a disincentive for providers to participate in Medicaid, which ultimately impacts on beneficiaries' access to quality medical care. Although states should have considerable flexibility in fashioning innovative financing for Medicaid, there must be basic federal standards relating to provider reimbursement designed to ensure access to quality medical care, both in a fee-for-service and a capitated environment. In order to regain equity in Medicaid provider reimbursement and to allow states flexibility in spending their Medicaid dollars in the most efficient manner possible, the Boren Amendment should be replaced by broader reimbursement/access standards for all Medicaid providers and standards for payment to plans that are aimed at ensuring access to care.

National provider reimbursement standards should be established, either by HCFA or by the Physician Payment Review Commission ("PPRC"), to ensure access to coverage for Medicaid beneficiaries. The AMA and other interested parties should have an opportunity for formal input into the development of these standards. Access must be defined broadly and should encompass reasonable choice of system of health care delivery, physician and health care facility.

In order to ensure compliance with national standards, states should designate the state Commissioner of Insurance or other appropriate state agency to oversee Medicaid provider reimbursement levels. The AMA supports basing provider reimbursement on the following:

- In the fee-for-service arena, state Medicaid programs should utilize the Medicare RBRVS with a single conversion factor for physician reimbursement.
- Any Medicaid payments or reimbursement based on capitation must be premised on sound actuarial and utilization assumptions.
- If plans utilize provider fee withholds or other financial incentives for providers to limit care, they must be equitable, particularly as compared to other payors. Financial incentives should not be linked to a provider's treatment decisions for a specific patient and should take into account a provider's "case mix" of patients.

Another critical step to ensuring access is the development of federal and state incentives, with input from physician organizations and practicing physicians, to encourage physicians and other providers to practice in underserved rural and urban areas. Incentives should include some or all of the following: reimbursement enhancements to physicians practicing in rural areas or medical service areas in the inner-city where the poverty rate exceeds a certain threshold; clear state and federal antitrust guidelines for physicians practicing in underserved areas that allow physicians to more effectively pool their resources and otherwise work together in these areas; tax credits for physician practices in underserved rural and inner city areas to help make up practice-related income differentials for choosing to practice in those areas; loan forgiveness programs for practice in underserved areas; financial assistance with start-up costs; and assistance with property and casualty insurance costs.

PROHIBITION OF COERCIVE METHODS OF SECURING PROVIDER PARTICIPATION IN MEDICAID

Appropriately financed state Medicaid programs, which offer adequate reimbursement and safeguards for the clinical decisionmaking process, will provide the necessary incentives for physician participation. Providers, like other individuals, should be free to enter into contracts that they choose and should not be subject to coercive measures, such as licensure requirements, "tying" arrangements that link provider participation in a program or plan with participation in Medicaid, or other requirements that impair a provider's ability to decline to accept Medicaid beneficiaries. States and managed care entities with Medicaid contracts should be prohibited from coercing provider participation in Medicaid through measures including, but not limited to, licensure requirements or health plan contractual requirements that require treatment of Medicaid patients.

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[2] Physician Payment Review Commission, *Annual Report to Congress, 1994,* chapter 18.

PROHIBITION OF SELECTIVE REVENUE TAXATION OF PHYSICIANS AND OTHER HEALTH CARE PROVIDERS

States have historically utilized provider taxes or fees to obtain federal "matching" funds and finance Medicaid expansions and other health system reform efforts. The AMA supports efforts to expand access to health coverage; however, we firmly believe that such efforts should be financed in an equitable manner that spreads the cost over the entire state, not just to providers who are actually providing necessary services within the state.

States should be prohibited from imposing selective revenue taxes on physicians and other health care providers and using such provider taxes or fees to fund health care programs or to accomplish health system reform.

EMERGENCY ROOM CARE

Inappropriate use of emergency rooms by Medicaid beneficiaries is one component contributing to spiraling Medicaid costs. States should create incentives for Medicaid beneficiaries to properly utilize emergency rooms. Such measures include, but are not limited to, programs for nominal copayments for emergency room visits.

CONCLUSION

The AMA applauds this Committee for seeking input regarding the Medicaid program and how best to achieve its restructuring. Regardless of whether the mechanism is a block grant program, a continuation of the current program with expedited state Medicaid waivers, or a program that would combine a block grant approach for certain portions of Medicaid with an expedited waiver process, it is imperative that the function of Medicaid as a safety net for the nation's poorest and most vulnerable populations be maintained. Our proposal for transforming Medicaid attempts to achieve the necessary balance between state flexibility and the need to establish national standards of accountability. Such safeguards are essential to ensuring that state Medicaid programs fulfill the crucial objective of the Medicaid program—to improve access to quality medical care for the program's beneficiaries.

Statement of Catholic Charities USA

(PRESENTED BY REV. FRED KAMMER, SJ, PRESIDENT)

Thank you for the opportunity to provide written testimony regarding the Medicaid program.

Catholic Charities USA is the nation's largest private network of social service organizations. Some 1,400 agencies and institutions with more than 272,000 staff members and volunteers work to reduce poverty, support families, and empower communities in the United States.

More than 3.8 million people turned to Catholic Charities for help in 1993. People of all religious, national, racial, social, and economic backgrounds receive services from Catholic Charities. Among our many services, Catholic Charities agencies provide foster home care and residential treatment for over 95,000 troubled or abused youth who depend on Medicaid for their medical needs.

We have both the experience and the responsibility to stress our concerns about the severe budget reductions and proposed block granting of the Medicaid program now being considered. Medicaid currently provides basic health and long term care coverage for over 33 million Americans, including one in four children. Cuts of the magnitude proposed, $182 billion over seven years, will have substantial impacts on state budgets and states' ability to pay the cost of health care for children, elders and disabled persons. Such severe reductions in funding will force state legislators to make crucial decisions regarding reductions in eligibility and services.

In addition, proposals changing Medicaid from an individual entitlement into a block grant with an aggregate cap will only magnify problems for the states and further jeopardize beneficiary coverage. Block grants jeopardize coverage by repealing federal guarantees of eligibility and benefits that were established to protect this fragile population. Block grants also deny states the flexibility to respond economic downturns and increasing numbers of eligible beneficiaries. With federal Medicaid funds capped, the federal government would no longer be required to help states cover increased numbers of eligible people, therefore forcing states again to reduce eligibility or cut services.

Two categories of vulnerable people are at special risk if the Medicaid program is cut too deeply or block granted. The first group are nursing home patients. Two thirds of Medicaid dollars are spent on the acute and long term care of frail elderly and disabled people who have been made destitute and dependent by their severe illnesses. Medicaid reimbursements are already dangerously low for nursing home care, and capping the federal Medicaid share puts these helpless people at greater risk of truly horrifying neglect.

The second group at risk is low income children. In the 1980s, Congress created a nationwide system of ensured health coverage for low income children and pregnant women and it established minimum standards for eligibility, benefits, and access to care. Such standards have reduced the past inequities of variation in state eligibility and benefit rules, as well as the practice of excluding children and pregnant women of low-income, working families. The history of the Medicaid program demonstrates that children, especially children in foster care, do not have the political clout to protect their interests in state capitols. Without federal guarantees and mandates children will be greatly disadvantaged.

We are opposed to eliminating the entitlement status of individuals under the Medicaid program. Eliminating the entitlement status would jeopardize coverage for some of the most vulnerable individuals of our country including women and children. We realize some Medicaid savings are needed to achieve federal budget goals, however, Congress should take the responsibility to make the necessary program changes, rather than set abstract funding caps and abandon the program in the laps of the states. A closer look at how the $182 billion in Medicaid savings might be achieved would help Members of Congress understand that cuts of this magnitude are insupportable.

Only by a careful assessment of specific proposals can Congress exercise its responsibility to ensure that the poorest and sickest Americans do not suffer or pay with their lives in the worthy fight against deficit reduction.

STATEMENT OF THE MENTAL HEALTH LIAISON GROUP

On behalf of:

American Academy of Child and Adolescent Psychiatry
American Association for Marriage and Family Therapy
American Association for Partial Hospitalization
American Association of Children's Residential Centers
American Association of Pastoral Counselors
American Association of Psychiatric Services for Children
American Association of Retired Persons
American Counseling Association
American Family Foundation
American Group Psychotherapy Association
American Nurses Association
American Occupational Therapy Association
American Psychological Association
American Psychiatric Association
American Psychiatric Nurses Association
Bazelon Center for Mental Health Law
Cult Awareness Network (CAN)
National Association for Rural Mental Health
National Association of Homes and Services for Children
National Association Psychiatric Treatment Centers for Children
National Association of Social Workers
National Depressive and Manic Depressive Association
National Federation of Societies for Clinical Social Work
National Foundation for Depressive Illness, Inc.
National Mental Health Association
World Association for Psychiatric Rehabilitation

Mr. Chairman, the above signed organizations concerned about mental health services are pleased to present our views on the implications for mental health services in Medicaid reform efforts. Thank you for making our views part of the Committee's record. The hearing permits us to stress the importance of mental health coverage in the Medicaid program for adults with serious mental illness and children with severe emotional disturbance.

Medicaid represents a major source for financing mental health care. In 1990, Medicaid mental health expenditures were $8.1 billion, representing 19 percent of the total $42.4 billion estimated public and private spending for mental health services.[1] In addition to its significance as a major financing source, Medicaid has also encouraged the expansion of community-based treatment modalities such as psychiatric rehabilitation, case management, personal care services, day treatment and intensive in-home services.

Currently 6.2 million people with disabilities receive Medicaid coverage through their eligibility for SSI, about one-third or 2 million of these are adults with mental illness and children with severe emotional disturbance. In addition to people who qualify for Medicaid because they have a mental disability, there are many others—including victims of domestic violence and senior citizens in nursing homes—who depend on Medicaid for their mental as well as physical health coverage. AFDC recipients have a higher prevalence of mental disorders like depression than people not receiving financial assistance.In some states, people with mental illness qualify for Medicaid because their high medical expenses render them "medically needy." For people with serious mental illness, Medicaid's continued viability and vitality is critical. It is a lifeline essential to their recovery and restoration of function and independence. Under today's private market limitations, e.g. pre-existing conditions exclusions, it is not replaceable by other health coverage.

To participate in Medicaid, states must agree to provide certain mandated services to eligible individuals. In addition, states have the option to offer additional services authorized in the federal law. By combining mandatory and optional service categories, many states have created a comprehensive array of inpatient, outpatient and rehabilitative services which effectively address the clinical needs of beneficiaries with serious mental illness. For children, states are required to go beyond the coverage in their state plan to provide all services included in the Medicaid statute necessary to treat or ameliorate any condition identified by a comprehensive screen.

Current Law Medicaid Mental Health Services

Mandatory Services relevant to mental health care are:
- Physician/psychiatrist services.
- Inpatient and outpatient services in general hospitals.
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children.

Optional Services relevant to mental health care are:
- Other diagnostic, screening, preventive and rehabilitative services used in 33 states to cover psychiatric rehabilitation for adults and children.
- Clinic services, which in 39 states include mental health clinic services.
- Prescription drugs, covered in all states, although some states limit psychotropic drug coverage.
- Targeted case management. 39 states include services for people with mental illness in at least a portion of the state.
- Services of other health professionals, used to cover clinical psychologists in 38 states, clinical social workers in 5 states and advance practice psychiatric nurses in 12 states.
- Personal care services, covered for individuals with mental illness in 13 states.
- Inpatient psychiatric services for children under age 21, including services in residential treatment facilities, covered in 44 states.
- Inpatient psychiatric services for adults over age 64, covered in 45 states.

The Congressional Budget Resolution assumes that Medicaid will be converted into a capped block grant with flexibility to the States to redesign their medical assistance programs. However, the amount of money allocated to the block grant annually would not keep pace with medical price inflation or demographic changes. Over the next 7 years, the rate of annual increase in Federal Medicaid payments would decline to 4% annually and remain at that level of increase for the indefinite future. The rate of growth assumed in the Resolution is smaller than the annual rate Medicaid has experienced any time in its history.

The argument that the limited growth rate can be achieved without doing extraordinary damage to the program's current beneficiaries is fallacious. It asks us to believe that inflation, particularly medical price inflation, is not real. It ignores the reductions in employer based health care coverage which places greater pressure on Medicaid. It disregards the growing numbers of people who are aged and disabled.

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[1] Richard G. Frank, Thomas G. McGuire, et al. "Paying for Mental Health and Substance Abuse Care," Health Affairs, Spring (I), 1994, p.336.

It presumes that technology will not improve quality of care with a concomitant increase in prices.

Under current law, Medicaid beneficiaries are estimated to increase from 36 million currently to 46 million in 2002 due to population changes, increases in poverty and the phase-in of coverage of poor children. Analysts estimate that reductions in Federal assistance combined with state fiscal pressures are likely to mean that over 90 percent of the expected growth in the covered population may not occur (i.e., only 36.8 million beneficiaries would be covered by 2002), even if states pursue stringent cost containment efforts.[2] They also estimate that 1.4 million people with disabilities will be cut from the beneficiary rolls by 2002 under the reductions passed by the House ($185 billion.)

Make no mistake about it—these are real cuts. They will hurt deeply. They will hurt one of the most vulnerable segment of the Medicaid population: the 6.2 million people with disabilities, one-third of whom have serious mental illness.

Loss of Medicaid coverage will mean that people with serious mental illness will lose access to essential services and supports. This will place unreasonable burdens on families; exacerbate disabling conditions and lead to unnecessary institutional care. Additionally, private insurance costs will rise because hospitals and other providers will be forced to provide uncompensated care.

Under a capped arrangement, states would have to bear the full risk of any costs beyond the capped amount, even where added costs result from factors beyond a state's control, such as population growth or economic recession. Caps place great pressure on states to restrict eligibility, cut services or diminish quality. People with chronic need for acute and long term services—such as people with serious mental illness—will be the most severely affected.

Even with block grants, federal oversight must continue to ensure quality of care and consumer protection. Without such safeguards, we fear state service systems could deteriorate, recreating the alarming conditions that originally prompted federal standards. Once again, people with serious mental illness could be vulnerable to abuse and substandard services in many states.

Whatever the final form of the Medicaid restructuring and the level of annual payments, the Federal treasury will continue to finance a major part of the costs, estimated to exceed $100 billion in fiscal year 1996 alone. Expenditures of this magnitude require that federal interests be protected; that states be held accountable, both in fiscal and programmatic terms for the funds they receive; and that the public know how the money has been spent.

Policy Principles Guiding a Restructured Medicaid Program

We support reforms in Medicaid that will improve acute and long term services for people with serious mental illness. We also do not oppose proposals to achieve cost economies in the program. However, the two objectives must be linked. That is, efforts that reduce the rate of Medicaid growth must be carefully crafted with their short and long term consequences for beneficiaries uppermost in mind.

We contend that Medicaid reform which serves the needs of its beneficiaries while reducing the rate of growth can be achieved only in the context of general health care reform. Medicaid is a significant part of the national health care system. It cannot be changed in a vacuum. The substantial cuts in Medicaid which the Budget Resolution proposes, without overall reform in the health care system, will only lead to more people being uninsured, fewer important services being covered, lower rates of participation by providers in the program, and more cost shifting onto private insurance by hospitals and other providers.

While Congress rejected comprehensive health care reform proposals of the Administration, House and Senate committee and individual members last year, the need for reform did not thereby disappear. We suggest that this Committee take the time to evaluate what still can be done to improve the nations' system of health care before it slashes health care for our most vulnerable populations: lower income families, the frail elderly and persons who are disabled.

We believe that the federal legislation restructuring Medicaid can offer exciting opportunities for people with mental illness, if it is properly written. Potentially, the future Medicaid program could:

—Expand home and community based services to better serve adults and children with serious mental disorders.

—Increase access to comprehensive mental health services through managed care plans with appropriate quality and performance safe guards.

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[2] John Holahan and David Liska, "The Impact of the House and Senate Budget Committees' Proposals on Medicaid Expenditures." Prepared for the Kaiser Commission on the Future of Medicaid, May 1995, Table 11.

—Increase opportunity to integrate mental health and substance abuse services with other health care.

—Increase potential for states to expand services to people not currently covered by Medicaid.

However, to achieve these improvements, the legislation should be guided by a set of criteria which protect the interests of low-income people with mental illness as well as other Medicaid beneficiaries and the tax-paying public in general. We support the following ten criteria and recommend that they form the basis for legislative reform:

- People who receive SSI/AFDC benefits must continue to have an entitlement to Medicaid services.
- Medicaid should continue to be available as a safety net for people classified as "medically needy" e.g. people with serious mental illness who are unable to obtain or have exhausted their private insurance coverage.
- Medicaid beneficiaries, including people with serious mental illness, should have a broad range of services available, but with an enhanced access to those services provided in community settings.
- Medicaid programs should ensure patient access to all clinically appropriate care without discrimination on the basis of diagnosis.
- States should be required to maintain at least their current level of Medicaid spending. Further, states should be required to implement programs which enhance collaborative service delivery, limiting duplication and reducing inefficiency.
- The Federal government should exercise a leadership role in establishing, in consultation with the states, performance standards and evaluating state rules governing eligibility and amount, duration and scope of services.
- The Federal government and the states should be required to develop systems for collecting and distributing comparable data on access to care and the costs, utilization and effectiveness of services.
- The Federal government and the states should ensure the confidentiality of personally-identifiable medical information. Information that identifies an individual must not be released without the individual's consent, except in narrowly-defined emergency circumstances.
- Mental health consumers and their representatives should have a voice in decision making affecting the organization and delivery of mental health services.
- Managed care must have clearly defined and uniformly applied consumer protection standards to ensure access to quality treatment throughout the full continuum of care. "Flexibility" in managing mental and behavioral care must not mean denial of appropriate care in order to reduce costs or operate within budget limits.

Thank you for the opportunity to present the thoughts of the mental health community on the restructuring of the Medicaid program—a legislative change that could have either positive or disastrous impact on people with mental illness. The outcome will depend upon the care and concern you devote to the consequences of the legislation for the people who depend upon Medicaid for their health care.

STATEMENT OF VOICE OF THE RETARDED

(SUBMITTED BY POLLY SPARE, PRESIDENT)

On the behalf of Voice of the Retarded (VOR), I appreciate the opportunity to provide comment on the importance of the Medicaid program and reform initiatives for severely disabled Americans. VOR thanks you for including our written remarks in the Committee's hearing record.

VOR is a not-for-profit association which represents thousands of mentally retarded persons and those who care for them across the United States. The association favors continued access to a full continuum of health care service options for our diverse population. As parents and relatives of severely retarded citizens, we seek to preserve freedom of choice in selecting residential living alternatives, including institutional care, which best suit the individual needs of the mentally retarded, given wide variances in mental and physical capacities.

We understand that a representative of the ARC presented testimony before the Committee on the behalf of the Consortium for Citizens with Disabilities (CCD). We concur with many of the points made in the CCD testimony relative to Medicaid managed care for the disabled population, as well as commentary relative to the loss of entitlement protection afforded at the federal level vis-a-vis state discretion. We, however, strongly disagree with the CCD remarks relative to "eliminating the bias toward institutional care" and implications that home and community-based services be established at the expense of such care for the reasons outlined herein.

I, myself, am the mother of two severely mentally retarded adults: Chris, a medically fragile 39 year old, who is blind, deaf and wheelchair-bound with the mental age of 9 months, and Sandra, also medically fragile and osteoporotic, who is a 42 year old with the mental capacity of an 18 month old baby. VOR receives absolutely no federal grants, nor other sources of federal funding, and we operate exclusively on a donation basis—primarily though contributions from concerned parents of mentally retarded persons. We are an organization of volunteers devoted to improving the quality of life and well being of our family members.

In many cases, the Medicaid program provides the only access available to vital health care services for many of our most vulnerable citizens, the severely retarded. As the Committee examines options for reforming the Medicaid program, VOR requests that Committee members carefully and fully explore the implications of reform initiatives. We urge the Committee to examine how to maintain the safety net of critical health services for the most needy, and how to assure that any new policy or reform maintains access and support to a full continuum of care for the disabled, including institutional care, so that the parent, guardian or eligible individual has the freedom to choose which setting is most appropriate to meet the retarded individual's needs.

The U.S. Congress has given retarded citizens and their guardians an important choice in providers: the Social Security Act mandates a "choice option" between home, community and institutional care; and report language of the developmental disabilities amendments of 1994 states the Act "may not be read as a federal policy supporting the closure of institutions." These existing policies have been ratified by the government and continuously reaffirmed throughout various Administration's and should be sustained.

To assure that institutional care is sustained as a viable alternative for retarded citizens, we ask that Medicaid support for institutional options be maintained, and not sacrificed as Congress tackles the growth of Medicaid spending. While Congress may seek to control Medicaid spending by converting it to a block grant, it is crucial that the federal government or state governments do not shift resources from one program, such as institutions, to another, such as home and community-based care, without carefully examining the consequences.

Home and community-based programs provide some retarded citizens with the opportunity to develop active and, in many cases, productive roles in society. However, such programs should not be established at the expense or to the exclusion of institutional care facilities, which provide cost effective and appropriate care for those retarded people who are too cognitively impaired and/or medically fragile to be properly cared for in home environments. One-size-fits-all programs ignore the real needs of these citizens.

Furthermore, studies have shown that institutional care is actually more cost effective for severely retarded persons. Home and community-based programs may not save the Federal Government any money. In fact, when the needs of the severely retarded and/or medically fragile are taken into account, the cost of such home and community-based programs are *more expensive* than quality institutional care.

According to a study prepared for the New Jersey Developmental Disabilities Council:

> "A final cost saving strategy, consistent with the DD Council's recent policy statement in favor of closing the developmental centers would be to discontinue developmental center and private institutional care (PIC), operations . . . (T)he fiscal advantage of this strategy depends heavily on the mix of community services into which developmental center and PIC residents would move. If they were to mirror current community residential and day program utilization patterns, there would be a projected surpluses of $132 million in FY 97 and $136 million in FY 2000 . . . On the other hand, *if they were to move into specialized group homes and day training services exclusively (the implication is to close all institutions) there would be projected deficits of $185 million in FY 97 and $243 in FY 2000."*[1]

The study concludes that:

> "The risk of losing federal ICF-MR [institutional] funding would . . . decimate the service system. Even the projected savings associated with closing the developmental centers and private institutions would not free enough funds to meet

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[1] Ashbaugh, J. and Grady, L. (June, 1994). "Impacts of Today's Fiscal Realities and Tomorrow's on the System of services for People with Developmental Disabilities in New Jersey," prepared for: New Jersey Developmental Disabilities Council: Cambridge: Human Services Research Institute.

> projected demand. In fact, to the extent that specialized group home and day training services are the community alternatives of choice, the closing could result in higher rather than lower costs."

The New Jersey Developmental Disabilities Council subsequently published a news letter concluding that:

> "There has been the assumption that closing the institutions would allow the division to begin to serve some of the people on the waiting list. It has to be clear that, to the extent that our community system continues to rely heavily on group homes, this also isn't so."[2]

Whereas new home and community-based programs can serve the needs of many functional, retarded citizens, evidence suggests that funding such programs with institutional care funding is not the solution. As home and community-based care programs continue to expand, there must be assurances that an institutional care option will remain viable for those who are best served by it.

VOR appreciates the opportunity to work with the U.S. Congress as you consider reform measures to the Medicaid program for the thousands of mentally retarded citizens we represent.

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[2] The New Jersey Developmental Disabilities Council, "People with Disabilities Newsletter (July, 1994, Vol. IV, No. 3).

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